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EXPLANATION OF

H.R. 6878

THE MEDICARE, UNEMPLOYMENT COMPENSATION, AND PUBLIC ASSISTANCE AMENDMENTS OF 1982

INCLUDING SUMMARY, EXPLANATION, AND COST ESTIMATES OF THE CONGRESSIONAL BUDGET OFFICE

AUGUST 2, 1982

Prepared for the use of the Committee on Ways and Means by its staff

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CONTENTS

	Page
I. Introduction	1
II. Summary of provisions	3
A. Medicare changes	3
B. Unemployment compensation amendments	8
C. Aid to families with dependent children and child support enforcement amendments	11
D. Supplemental security income amendments	14
III. Section-by-section explanation	15
Title I—Medicare changes	15
Subtitle A—Changes in benefits and coverage	15
Sec. 101. Hospice care	15
Sec. 102. Coverage of extended care services without regard to 3-day prior hospitalization requirement	22
Sec. 103. Medical coverage of, and application of hospital insurance tax to, Federal employment	23
Subtitle B—Reimbursement and payment changes	24
Sec. 111. Payment for inpatient hospital services	24
Sec. 112. Optional alternative medicare program (medicare vouchers)	30
Sec. 113 Payments to health maintenance organizations	32
Sec. 114. Prohibiting recognition of payments under certain percentage arrangements	36
Sec. 115. Reimbursement for assistants at surgery	37
Sec. 116. Interest charges on overpayments and underpayments	38
Sec. 117. Prohibiting payment for Hill-Burton free care	39
Sec. 118. Prohibiting payment for anti-unionization activities	40
Sec. 119. Eliminating lesser-of-cost-or-charge provision	40
Sec. 120. Temporary delay in periodic interim payments	41
Subtitle C—Miscellaneous changes	42
Sec. 121. Audit and medical claims review	42
Sec. 122. Extending medicare proficiency examination authority	42
Sec. 123. Prohibiting retroactivity of regulations regarding access to books and records	42
Title II—Unemployment compensation provisions	42
Subtitle A—Federal supplemental unemployment compensation program (secs. 201-206)	44
Subtitle B—Taxation of unemployment compensation (sec. 211)	48
Subtitle C—Financing provisions (secs. 221-225)	49
Sec. 226. Treatment of certain employees of institutions of higher education	58
Subtitle D—Short time compensation (secs. 231-234)	59
Title III—Aid to families with dependent children and child support enforcement programs	60
Sec. 301. Treatment of earnings	60
Sec. 302. Repeal of gross income limitation	67
Sec. 303. Treatment of earned income credit	68
Sec. 304. Exclusion from income	69
Sec. 305. Advance payment to States with respect to AFDC expenditures	69
Sec. 306 Job search	70
Sec. 307 Exclusion from income of certain State payments	73
Sec. 308 Cost of services for non-AFDC families	74

Page

Title III—Aid to families with dependent children and child support enforcement programs—Continued
Sec. 309 Reduction in certain Federal payments to States under child support enforcement program 74
Sec. 310 Allotments from pay for child and spousal support owed by members of the uniformed services on active duty 76
Sec. 311 Reimbursement of State agency in initial month of ineligibility for AFDC 76
Title IV—Supplemental security income program 77
Sec. 401 Supplemental security income accounting period 77
Sec. 402 Phaseout of hold harmless protection 79
Sec. 403 Exclusion from resources of burial plots and certain funds set aside for burial expenses 80
Sec. 404 Mandatory passthrough under State supplementation provisions 82
IV. Budget impact and cost estimates 83

I. INTRODUCTION

This document has been prepared by the staff of the Committee on Ways and Means as an explanation to accompany H.R. 6878. This bill, the Medicare, Unemployment Compensation, and Public Assistance Amendments of 1982, was introduced on July 28 by Mr. Rostenkowski and Mr. Gradison. H.R. 6878 embodies the tentative decisions made by the committee for drafting purposes on July 15, pursuant to the directives contained in the First Concurrent Resolution on the Budget for Fiscal Year 1983.

On July 27, before taking final action on the July 15th decisions, the committee voted to go directly to conference on the Senate amendment to H.R. 4961. (H.R. 4961, as amended and approved by the Senate, contains the spending and tax provisions developed by the Senate Finance Committee pursuant to the fiscal year 1983 First Concurrent Budget Resolution.) Because of the decision to go to conference on H.R. 4961, no further formal action on the decisions made on July 15 will be made by the committee. In moving to go to conference on the Senate amendment, however, the Chairman of the committee noted in his statement that

> With regard to the spending reductions, the House conferees will have to remain faithful to the overwhelming desire of Members on both sides of the aisle to make reductions in as compassionate a way as possible with the least impact on beneficiaries, particularly in the medicare program. I believe that the spending reductions agreed to last week by the Committee on Ways and Means achieve that end. Those spending reductions are being introduced today by myself and my colleague from Ohio, Mr. Gradison, and will serve as the blueprint for the House position in conference on the spending reduction issues.

This staff document, which explains the bill introduced by Mr. Rostenkowski and Mr. Gradison (H.R. 6878), has been prepared to provide further information on the committee decisions which may serve as a reference point for the conferees and interested members of the public. This document is not a committee report, and its contents have not been formally approved by the committee.

II. SUMMARY OF PROVISIONS

A. Medicare Changes

1. Hospice care (section 101)

The bill would provide medicare reimbursement for hospice services to terminally ill medicare beneficiaries who elect to receive hospice benefits in lieu of other medical benefits. The provision would be effective August 1, 1983 and would sunset September 30, 1986.

2. Coverage of extended care services without regard to 3-day prior hospitalization requirement (section 102)

The Secretary of Health and Human Services is directed to provide skilled nursing facility coverage without regard to the current 3-day prior hospital stay requirement at such time as, through reimbursement changes or other adjustments, he determines that this will not lead to an increase in program costs, and that it will not alter the acute care nature of the benefit.

3. Medicare coverage of, and application of hospital insurance tax to, Federal employment (section 103)

Under present law, Federal employees generally are not covered under Social Security and are therefore not subject to FICA taxes. Nonetheless, it is estimated that a significant portion of all Federal employees and retirees age 65 and above qualify for medicare benefits either on the basis of their own employment outside government or on that of their spouse. As a general rule, Federal employees who qualify for medicare do so on the basis of fewer quarters of coverage than other beneficiaries.

The bill would require, effective January 1, 1983, that Federal employment be subject to the hospital insurance portion of the FICA tax. Consequently, Federal employees would earn credit toward, and may qualify for, medicare protection on the basis of their Federal employment.

A transitional provision is included to assure that individuals who are in the employ of the Federal government both during and before January 1983 will be able, if necessary, to have their pre-January 1983 Federal employment considered for purposes of determining eligibility for medicare part A.

4. Payment for inpatient hospital services (section 111)

A. Reimbursement Limits

Existing section 223 reimbursement limits on inpatient routine costs would be expanded to encompass total operating costs, and

adjustments would be made to take account of the relative complexity of the cases treated in each hospital.

The limits for a hospital would be set initially at 120 percent of the mean cost of hospitals in its comparison group. The Secretary of Health and Human Services would have the authority to reduce the limit to 115 percent in fiscal year 1984 and to 110 percent in fiscal year 1985. Hospitals would be held harmless against a decrease in average reimbursement per case.

Currently existing hospitals of less than 50 beds would be exempted from the expanded section 223 limits. The Secretary would be directed to determine and apply adjustments to the reimbursement limits, to the extent he believes appropriate, to take into account the special needs of psychiatric hospitals and public or other hospitals that provide services to a significantly disproportionate share of medicare and low-income patients.

B. Incentive Reimbursement

Under a temporary 3-year provision, hospitals would be given a medicare target reimbursement rate of increase aimed at providing an incentive to control costs.

The target rate of increase would be applied to average inpatient costs per case and would be calculated on the basis of increases in the hospital "marketbasket" (the wages and prices hospitals must pay) plus one additional percentage point. (CBO is projecting the marketbasket increase at 8.7 percent in fiscal year 1983.)

Hospitals with costs *below* the target would be paid 50 percent of the difference between their costs and the target, up to a maximum of 5 percent of their target amount.

Hospitals with costs *above* the target would be paid: (a) 50 percent of excess costs that are up to 105 percent of the target; (b) 25 percent of excess costs that are between 105 to 110 percent of the target; and (c) none of their costs that exceed 110 percent of the target amount.

C. Prospective Payments

The Secretary would be required to develop a prospective payment plan for hospitals and skilled nursing facilities, to be submitted to the Congress no later than December 31, 1982. The hospital prospective payment plan, which would be designed to produce savings at least equal to the savings that would have been achieved in the absence of such a plan, would go into effect October 1, 1983, unless it is disapproved through legislation adopted by both Houses of Congress by July 1, 1983. In the absence of a prospective payment plan meeting these specifications, the other reimbursement provisions would continue in effect.

D. Recognition of State Hospital Cost Control Systems

Medicare reimbursement could, at the request of a State, be based on a reimbursement control system in a State if the Secretary is satisfied that over a 3-year period it will result in medicare payments no greater than would otherwise have been paid.

5. Optional alternative medicare program (medicare vouchers) (section 112)

The bill would establish a medicare voucher system. Under this system, medicare beneficiaries would have the option of choosing to receive a voucher which could be applied toward the premium of a qualified health care plan. The amount of the voucher would be based upon the average medicare expenditure per beneficiary in an area, actuarially adjusted in a manner to be determined by the Secretary (including such adjustments as age, sex and disability status). The voucher amount would be indexed annually to reflect changes in the medical care component of the Consumer Price Index.

To become a qualified health care plan, a plan would be required to provide at least those health care services which are covered by parts A and B of medicare and to hold an annual open enrollment period. An individual would be permitted to elect, during such enrollment period, to resume receiving benefits under the regular medicare program.

The provision would not be implemented until the Secretary of Health and Human Services is reasonably certain that the methodology to assure actuarial equivalence can be implemented.

6. Payments to health maintenance organizations (section 113)

The bill would provide a medicare payment option for health maintenance organizations (HMOs). HMOs under a risk contract would receive a prospectively determined per capita payment for each enrollee set at 95 percent of the average cost of providing services to a medicare beneficiary in the fee-for-service sector. To participate in medicare, the HMO would be required to be either federally qualified or meet certain other specific requirements. The provision would not take effect until the Secretary of Health and Human Services is reasonably certain that the methodology for making adjustments to assure actuarial equivalence can be implemented.

7. Prohibiting recognition of payments under certain percentage arrangements (section 114)

Under the bill, where reimbursement to a provider is made on the basis of reasonable cost and where a provider has entered into a contract for services which is based on a percentage of the provider's reimbursement, costs incurred under the contract would not be considered reasonable. This provision would specifically not interfere with certain types of percentage arrangements which are customarily considered normal commercial business practices such as the commission paid to a salesman. For percentage arrangements entered into prior to enactment, the provision would not take effect until one year following enactment, or if earlier, 30 days following the date on which the provider can unilaterally terminate this arrangement.

8. Reimbursement for assistants at surgery (section 115)

The bill includes a provision which would prohibit reasonable charge reimbursement for assistants at surgery in hospitals where

96-955 O - 82 - 2

a training program exists in that specialty except in certain circumstances. Those circumstances include: (1) team physicians who perform complex medical procedures, or (2) concurrent care whereby a medical specialist also provides, or is available to provide, care during a surgical operation if the patient has another condition requiring care that the surgeon is unable to perform; and (3) exceptional medical services.

9. Interest charges on overpayments and underpayments (section 116)

The bill includes a proposal which would require interest payments with respect to medicare overpayments to providers. Interest would be at the rate earned by the medicare hospital insurance trust fund and would be charged beginning at the point at which the overpayment was finally determined. Similarly, the medicare program would be required to pay providers interest on underpayments.

10. Prohibiting payment for Hill-Burton free care (section 117)

The bill would prohibit medicare from recognizing, for purposes of reimbursement, free care delivered by a hospital in fulfillment of its Hill-Burton obligations.

11. Prohibiting payment for anti-unionization activities (section 118)

The bill would prohibit medicare from recognizing, for purposes of reimbursement, costs incurred for activities directly related to influencing employees with respect to proposed unionization.

12. Eliminating lesser-of-cost-or-charge provision (section 119)

Under current medicare law, providers of services are reimbursed based upon the lower of their reasonable costs or their customary charges. The bill would eliminate, with respect to all providers, the currently applied "lower of costs or charges" requirement, but only at such time as the Secretary of HHS determines that this will not increase medicare program costs.

13. Temporary delay in periodic interim payments (section 120)

Under present law, hospitals may elect to receive reimbursement through equal "periodic interim payments" (PIP), rather than through payments that fluctuate in relation to submission of individual claims. The bill would increase the payment lag in September of 1983 and 1984 for hospitals electing the PIP method, deferring the payments until the beginning of the next fiscal year. The normal PIP payment procedure would be fully restored in fiscal year 1985.

14. Audit and medical claims review (section 121)

The bill would mandate a $45 million increase in spending on provider auditing and claims review for each of the next three fiscal years.

15. Extending medicare proficiency examination authority (section 122)

The bill would extend to September 30, 1983, the authority of the Secretary of Health and Human Services to conduct a program to

determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet certain formal educational requirements.

16. Prohibiting retroactivity of regulations regarding access to books and records (section 123)

Section 952 of P.L. 96–499, the Omnibus Budget Reconciliation Act of 1980, requires that the Secretary of Health and Human Services or Comptroller General have access to the books and records of subcontractors who supply hospitals or other providers with goods and services valued at $10,000 or more over a 12-month period. The provision directs the Secretary to prescribe in regulations the procedures and criteria to be used in obtaining access to the appropriate books, documents and records. The regulations have yet to be proposed. The bill would prohibit the regulations, once issued, from being applied retroactively.

17. Administration's regulatory actions

The committee anticipated the prompt accomplishment of the Administration's planned regulatory actions and voted to give recognition to them and to the savings they are estimated to achieve. The actions include implementing a Health Care Financing Adminstration and private sector utilization review initiative; tightening reimbursment for hospital-based physicians; eliminating duplicative payments for overhead with respect to physcians who provide outpatient services; eliminating duplicate payment for private rooms; and establishing a single reimbursement limit for hospital-based and free-standing skilled nursing facilities and a single rate for hospital-based and free-standing home health agencies.
tal-based and free-standing home health agencies.

B. Unemployment Compensation Amendments

1. Additional weeks of unemployment compensation (sections 201–206)

Sections 201–206 establish a temporary program of emergency unemployment compensation benefits. This program provides unemployed workers who exhaust their State unemployment compensation benefits and Federal-State extended benefits up to a maximum of 13 additional weeks of benefits. These additional weeks of benefits would be payable in States where, due to high unemployment, the Extended Benefit program is triggered on. The program would be in effect from the date of enactment until September 30, 1983. Benefits and administrative costs would be paid for out of Federal general revenues.

2. Taxation of unemployment compensation benefits (section 211)

Section 211 reduces the income thresholds limiting the inclusion of unemployment benefits in adjusted gross income for Federal income tax purposes from $20,000 to $12,000 for single taxpayers and from $25,000 to $18,000 for married taxpayers filing jointly. This change applies to unemployment benefits paid on or after January 1, 1982.

3. Increase in Federal unemployment tax wage base and rate (section 221)

Section 221, effective January 1, 1983, increases the Federal unemployment tax (FUTA) wage base from $6,000 to $7,000 and the net Federal unemployment tax rate from 0.7 to 0.8. (The increase in Federal tax base will require States, that have not already done so, to raise the State unemployment tax wage base to at least $7,000.)

Effective January 1, 1985, the gross Federal tax rate will increase to 6.2 percent. This includes a permanent tax of 6.0 percent plus a temporary 0.2 percent that will remain in effect until all outstanding general revenue loans to the extended benefit (EUCA) account have been repaid. The offset credit will increase to 5.4 (90 percent of the permanent 6.0 tax rate). This means the net Federal tax rate will remain at 0.8 percent, paid on the first $7,000 in wages, until the EUCA account has paid off all general revenue loans, when it will drop to 0.6 percent. This means that States allowing reduced rates below 5.4 percent can do so only on an experience rating basis.

Raising the permanent gross Federal tax rate to 6.0 percent and applying a 90 percent offset credit increases the State "standard tax rate" from 2.7 to 5.4 (5.4 is 90 percent of 6.0). The State "standard tax rate" is the basic rate from which variations in employers' State unemployment tax rates are computed according to each

State's experience rating formula. No employer in a State can pay a State tax below the standard rate unless his rate is reduced on the basis of the employer's previous unemployment experience, as measured by the State's experience rating system.

4. Credit reduction not to apply when States make certain repayments (section 222)

Section 222 permits States that have outstanding Federal loans to make repayments out of their State trust fund accounts, in lieu of an increase in the net Federal unemployment tax rate on employers in the State. For tax years beginning after December 31, 1982, a State could use this alternative loan repayment method in any year in which it has a net increase in the solvency in the State trust fund and has sufficient funds to pay all estimated State unemployment benefits during the forthcoming six (6) month period.

5. Limitation on fifth year credit reduction (section 223)

Section 223 drops the additional credit reduction based on the State's previous 5-year benefit cost rate that applies in the fifth year a State has outstanding Federal unemployment loans. This amendment applies to a debtor State in any tax year beginning after December 31, 1982 in which the State has taken no action during the 12-month period ending on September 30 which has reduced the solvency of the State unemployment trust fund.

6. Interest on State loans transferred to extended unemployment compensation account (section 224)

Section 224, beginning after December 31, 1982, provides that interest paid by States on Federal unemployment compensation loans will be credited to the Federal extended benefit (EUCA) account until all advances from general revenues to EUCA have been repaid.

7. Deferral of interest in case of certain States with high unemployment rates (section 225)

Section 225 allows States with high unemployment to reduce payments of interest on Federal unemployment loans to twenty-five (25) percent of the amount due in any year, and thereby extend the payment of the total interest obligation over a four (4) year period. (Interest would be charged on to any deferred amount.) A State would be able to extend payment of interest due in any calendar year in which the State insured unemployment rate equalled or exceeded 6.5 percent during the six (6) months preceding the calendar year. The amendment is effective for interest due after December 31, 1982.

8. Treatment of certain employees of institutions of higher education (section 226)

Section 226, effective upon enactment, allows States to deny unemployment compensation benefits to non-teaching, non-research and nonadministrative employees of colleges and universities during periods between academic years or terms, if there is reasonable assurance the individual will be employed by the institution at the beginning of the forthcoming academic year or term. This

would make Federal law consistent in its policy toward such employees of all educational institutions. (Current Federal law *requires* States to deny benefits during recess periods to teachers, researchers and administrators in colleges, elementary and secondary schools, and *allows* States to deny benefits to other employees of elementary and secondary schools but not colleges.) The amendment also provides that retroactive benefits may be received by non-teaching, non-research, and non-administrative educational employees who were reasonably assured of employment in the second term or in the fall, but were subsequently not offered that employment.

9. Short-time compensation (sections 231–234)

Sections 231–234, in order to assist States to develop programs under which partial unemployment benefits are paid to workers of a company whose work-week is reduced in lieu of a temporary total layoff of some of the firm's employees, directs the Department of Labor to develop model legislation that can be used by States that wish to establish such short-time compensation (or "work-sharing") programs. The Department of Labor is directed to evaluate the operation and impact of any such programs implemented by the States and report its findings to Congress no later than October 1, 1985. This amendment is effective upon enactment.

C. Aid to Families With Dependent Children (AFDC) and Child Support Enforcement (CSE) Amendments

10. Treatment of earnings (section 301)

Section 301, in order to provide a financial incentive for AFDC recipients to find employment and continue working, modifies the "earned income disregards" in the AFDC program. Specifically, States would be required to disregard the following amounts of earnings in determining a family's monthly AFDC benefit: the first $50 of earnings, 20 percent of gross earnings (up to a maximum of $175), child care costs (up to a maximum of $160 per child) and one-third of remaining earnings. The $50 and one-third disregards would be applied in determining a family's AFDC benefit only if the family meets the State income eligibility requirements without the application of these disregards. States could deny either or both of the $50 and the "one-third" disregards to AFDC–UP families. There would be no time limitation on any of the disregards.

In addition, States would be required to disregard the earnings of a child in an AFDC family derived from his or her participation in a CETA youth program.

These amendments are effective October 1, 1982; however, States have the option of implementing them on any earlier date following enactment.

11. Repeal of gross income limitation (section 302)

Section 302 repeals the provision in current law that limits AFDC eligibility to families with a gross income at or below 150 percent of the State standard of need. Effective October 1, 1982 or earlier at State option.

12. Treatment of earned income credit (section 303)

Section 303 repeals the provision in current law that requires States to assume AFDC recipients with earnings are receiving the earned income tax credit (EITC) on an advance monthly basis. States would be required to count against the AFDC benefit only the amount of EITC actually received in any month by a family. Effective October 1, 1982 or earlier at State option.

13. Exclusion from income of certain State payments to AFDC children (section 304)

Section 304 clarifies that, in determining an AFDC family's benefits, States are to continue to exclude certain State-financed payments that a State has been making to meet certain needs of AFDC children. Effective October 1, 1982 or earlier at State option.

14. Advance payment to States with respect to AFDC expenditures (section 305)

Section 305 allows States to continue to receive Federal AFDC matching funds at the time the States issue AFDC checks, rather than receving Federal funds on the basis of historical check clear-

ance patterns as proposed in recent HHS regulations. HHS could require States to pay interest on Federal funds received prior to the clearance of AFDC checks. Effective for calendar quarters beginning after the calendar quarter in which the amendment is enacted.

15. Job search (section 306)

Section 306 allows States to require any or all AFDC applicants and recipients who must register with the WIN program to participate in a job search program. States may require applicants to particpate in the job search program for up to eight weeks beginning at the time of application, and for an additional eight weeks per year following the initial job search period. Effective upon enactment.

16. Exclusion from income of certain State payments made due to retrospective accounting requirement (section 307)

Section 307, for purposes of determining a family's AFDC benefit, excludes State funded payments received by the family in a previous month that were intended to make up the difference between the State determined needs of the family and the amount of AFDC paid, where such a difference occurs because of the lag period under the required retrospective accounting procedures. Effective upon enactment.

17. Cost of child support enforcement services for non-AFDC recipients (section 308)

Section 308 requires States to recover any costs of making child support collections on behalf of non-AFDC families by deducting the costs from the amount of any recovery made; or, at the option of the State, from the parent who owes the support. States could not deduct more than 10 percent of the amount of the child support collection. Effective October 1, 1982.

18. Reduction in certain Federal payments to States under child support enforcement programs (section 309)

Section 309 reduces the Federal matching rate for State and local child support services administrative costs from 75 percent to 65 percent, and reduces the child support enforcement incentive payments deducted from the federal share of collections from 15 percent to 12 percent. In addition, matching funds would no longer be provided for the costs of administrative personnel of courts who perform child support enforcement functions. Effective October 1, 1982.

19. Allotments from pay for child and spousal support owed by members of the uniformed services on active duty (section 310)

Section 310 requires allotments from the pay and allowances of any member of the uniformed service on active duty who fails to make child (or child and spousal) support payments. The amount of the allotment would be that of the support payment established under a legally enforceable administrative or judicial order. Effective October 1, 1982.

20. Reimbursement of State agency in initial month of ineligibility for AFDC (section 311)

Section 311 allows States to reimburse themselves from the amount of child support collected for any AFDC benefit that was already paid in the final month of eligibility. Thus, the family would not receive double payment for the same month, first in the form of AFDC and then through receipt of the proceeds of the support collection.

96-955 O - 82 - 3

D. Supplemental Security Income Amendments

21. Supplemental security income accounting period (section 401)

Section 401 establishes a one-month prospective accounting system in SSI. This repeals the 1981 Omnibus Budget Reconciliation Act requirement of a two-month retrospective accounting period, and allows SSI payments to be adjusted to take into account increases in Social Security and other indexed benefits the first month in which they are received by recipients. Effective the third month following the month of enactment.

22. Phase out "hold harmless" protection (section 402)

Section 402 continues to phase out SSI "hold harmless" payments. Existing "hold harmless" payments would be reduced by 60 percent in 1983, by 80 percent in 1984, and to zero by 1985. Effective upon enactment.

23. Exclusion from resources of burial plots and certain funds set side for burial expenses (section 403)

Section 403 would allow up to $1,500 in a cash burial reserve as an alternative to the exclusion in current law of the cash value of life insurance policies with face values of $1,500 or less. In addition, the value of burial spaces for an SSI recipient and his immediate family would be excluded. Effective the second month following the month of enactment.

24. Mandatory pass-through under State supplementation provisions (section 404)

Section 404 allows a State, in order to meet the Federal SSI cost-of-living pass-through requirement, to shift from the aggregate spending SSI pass-through option to the payment level option. In order to comply with this requirement, a State must not decrease its State supplementation level below the previous year's level. Effective June 30, 1982.

III. SECTION-BY-SECTION EXPLANATION

TITLE I. MEDICARE CHANGES

Subtitle A—Changes in Benefits and Coverage

Section 101: Hospice care

Present Law

Hospice care is increasingly being recognized as an alternative way of caring for the terminally ill. It is a mode of care that emphasizes palliative care (medical relief of pain) rather than curative care and is designed to address the physical, psychological and spiritual needs of the patient and the emotional needs of the family.

Under present law, the medicare program does not recognize hospice as a separate provider category. Although some hospice-type services are provided through existing providers (e.g., hospitals, skilled nursing facilities, home health agencies), medicare does not cover hospice as a distinct type of benefit and generally excludes payment for commonly provided hospice services such as respite care and custodial care in the home. Reimbursement restrictions under current law may preclude beneficiaries from receiving hospice benefits.

Explanation of Provision

The bill amends Title XVIII of the Social Security Act to provide for coverage of hospice care under the medicare program. The bill would establish a separate provider status for qualified hospices under the medicare program and would authorize reimbursement for covered hospice services under part A of medicare for terminally ill beneficiaries who elect to receive hospice care rather than other medicare benefits.

A medicare beneficiary electing hospice benefits would waive entitlement to all non-hospice benefits available under the medicare program except for services provided by his or her attending physician. The hospice care benefit would consist of entitlement to have payment made on his or her behalf (subject to the limitations in this provision) for hospice care for up to two periods of 90 days each and one period of 45 days, totalling 225 days. Medicare beneficiaries could qualify for hospice benefits only if they have a life expectancy of six months or less (equivalent to two periods of 90 days). The additional 45 day period, permitted under the provision, is to ensure that the beneficiary is covered under the medicare program if he or she continues to live beyond the six month period. Because the average length of stay in hospice programs is significantly shorter than 225 days, it is expected that the Secre-

tary, in reporting to Congress on the hospice benefit (as discussed later), will make recommendations for changes in the length of the hospice benefit, as he or she deems appropriate, in light of the experience of the Health Care Financing Administration's ongoing hospice demonstration projects and in light of program experience under this provision.

The provision requires that medicare beneficiaries choosing hospice benefits waive their rights (with exceptions) to other than hospice services. It is felt that continued receipt of non-hospice services, whose purpose is to effect a cure, would be inappropriate for beneficiaries selecting hospice care and inconsistent with the intention that the hospice benefit should be a substitute for, not an addition to, coverage of intensive, curative care under the regular medicare program.

In electing hospice benefits under this provision, an individual elects a particular hospice program and is deemed to have waived rights to have payment made for: hospice care provided by another hospice program (other than under arrangements made by the particular hospice program); non-hospice services furnished during this election, (other than physician's services furnished by the individual's attending physician); and services other than those provided by (or under arrangements made by) a particular hospice program, that are determined (in accordance with guidelines established by the Secretary) either to be related to the treatment of the individual's conditions with respect to which a diagnosis of terminal illness has been made, or to be equivalent to (or duplicative of) hospice care.

After an individual elects to have hospice care for a 90-day period, or for a subsequent 45-day period, the individual may revoke the election during the period. In such a case, the revocation would act as a waiver of the right to have payment made for any hospice benefits for the remaining time in the period. In addition, revocation during a period would mean that an individual would be deemed to have used all available hospice benefits for such period.

An individual may at any time after revocation, execute a new election for a subsequent period if the individual is otherwise entitled to hospice care benefits. In addition, an individual may, once in each period, elect to change hospice programs, in which case, appropriate adjustments would be made in reimbursement to the respective hospice programs.

For an individual to be eligible for hospice care in the first 90-day period, his or her "attending physician" and the medical director (or physician member of the interdisciplinary group) of the hospice providing the care, must each certify, not later than 2 days after hospice care is initiated, that the individual is terminally ill. At the beginning of a subsequent 90- or 45-day period, the medical director or physician member of the interdisciplinary group must recertify that the individual is terminally ill. With respect to an individual receiving hospice benefits, the "attending physician" means the physician whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual receives hospice care. It is noted that the individual may not have an "attending

physican". In such a case the medical director or physician member of the interdisciplinary group may provide for the certification; however, under such circumstances, the medical director or physician member may not be reimbursed for services under part B of medicare. The intent is to allow the individual's attending physician to continue to participate in the provision of care to his or her patient but to avoid unnecessary duplication if the individual does not have an "attending physician" and would otherwise have to find a second physician in order to certify terminal illness for purposes of this provision. In addition, if the hospice medical director or physician member of the interdisciplinary team is identified by the individual as being the individual's "attending physician", the medical director or physician member of the interdisciplinary group may provide for the certification alone, but may not be reimbursed under part B for such services.

For purposes of this provision, an individual is considered to be terminally ill if the individual has a medical prognosis of a life expectancy of 6 months or less.

The provision requires that a written plan for providing hospice care with respect to each beneficiary be established (before such care is provided by, or under arrangements made by, that hospice program) and periodically reviewed by the medical director and the interdisciplinary group of the hospice program and by the individual's "attending physician" (if other than the medical director or physician member of hospice's interdisciplinary group). The provision requires that the care provided to an individual follow the written plan of treatment established for the individual.

Under this provision, reimbursement for hospice providers of services would be an amount equal to the costs which are reasonable and related to the cost of providing hospice care (or which are based on such other tests of reasonableness as the Secretary may prescribe) subject to a "cap amount" described below. The amount of payment under this provision for hospice care provided by (or under arrangements made by) a hospice program located in a region (as defined by the Secretary) for an accounting year may not exceed the "cap amount" for the region for a year multiplied by the number of beneficiaries in the hospice program in that year (subsequently defined).

The "cap amount" is computed by requiring the Secretary to identify, by using medicare program records, those individuals (or a representative sample of individuals) who died during a base period (subsequently defined), in which the primary cause of death was cancer, and who had been provided medicare benefits during the six months preceding their deaths, and then dividing the amount of such payments by the number of such individuals. This amount would be adjusted to reflect the different costs of delivering health care in different regions of the country. The Secretary may use such indexes as he or she may have available to make this regional adjustment.

The regional "cap amount" for an accounting year is to be 40 percent of the regional average cost computed above. The "cap amount" would be increased or decreased by the same percentage as the percentage increase or decrease in the medical care component of the Consumer Price Index for all urban consumers (United

States city average), published by the Bureau of Labor Statistics, from the fourth month of the base period to the fifth month of the accounting year. The term "base period" means the most recent period of 12 months (ending before implementation of this provision) for which the Secretary determines he has sufficient data to make the determinations required above.

For purposes of computing hospice reimbursement, the "number of medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election with respect to the hospice program (not the number of periods a beneficiary elects) and have been provided hospice care in the accounting year. This number would be reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

In requiring a cap on the maximum reimbursement a hospice may receive in a year, the intention is to reflect concern regarding the potential for the cost of hospice care to increase as a result of the availability of medicare reimbursement for hospice care. The intention of the cap is to ensure that payments for hospice care would not exceed the amount that would have been spent by medicare if the patient had been treated in a conventional setting. The reimbursement cap has been established on the basis of recent data from the Health Care Financing Administration, used by the Congressional Budget Office in estimating the cost implications of this provision, which indicate that medicare reimbursement in the last six months of life of a beneficiary dying of cancer would on average exceed $19,000 in 1983. The cap amount would be, based on these assumptions, in excess of $7,000 per beneficiary. In actual experience, however, it appears that most hospices incur costs significantly below this amount for their patients.

The Secretary is, therefore, required to conduct a study to determine whether or not the method of reimbursement and the limitation on reimbursement, outlined above, are fair, and equitable and promote the most efficient delivery of hospice care. In addition, the Secretary would be required to examine the feasibility and advisability of developing and providing for a methodology for reimbursement of hospice care on a prospective basis. The Secretary would be required to transmit to the Congress, no later than January 1, 1986, the results of this study and include, if the report recommends that reimbursement for hospice care be made on a prospective basis, a description of the methodology for such reimbursement and recommended changes in legislation which may be required to implement such methodology.

In addition, the Secretary would be required to examine the appropriateness of the specific benefits covered within hospice care and include any recommendations for benefit changes in hospice care with the report he or she transmits to Congress.

As the hospice is at financial risk, within the reimbursement cap, for the provision of services to medicare beneficiaries, concern has been expressed that a hospice may "dump" patients from the hospice program for financial reasons, especially after the patients' medicare hospice benefit has been used up. The Secretary is required to examine any such allegations of "dumping" and include

in his or her report to Congress any recommendations for avoiding such activity or for providing for penalties in such cases.

The Comptroller General would be directed to report to Congress within six months after the date the Secretary's report is transmitted to Congress, but not later than March 1, 1986, on the adequacy of the Secretary's report.

The provision would establish a separate provider category for hospices under the medicare program. All hospice providers under this provision would be required to enter into a separate agreement with the Secretary under Section 1866 of the Social Security Act and to account separately for services rendered and funds expended in connection with the hospice program. It is understood that hospice care is different from, and an alternative to, traditional care and the objective in establishing separate provider agreements is to ensure accountability and control over the delivery of hospice services under this provision and to protect against possible fraud and abuse.

In order to avoid unnecessary administrative duplication and expense, it is expected that in the certification process, the Secretary would identify those conditions of participation which a hospital, skilled nursing facility or home health agency may already have satisfied as a certified medicare provider, and would avoid unnecessary and duplicative tests of compliance in such cases. It is not contemplated that an entirely separate and independent organization should be required to be created or that duplicative office facilities and administrative structures should be mandated.

Under the provision, hospice care means the following items and services provided to a terminally ill individual by, or (subject to certain limitations) under arrangements made by, a hospice program pursuant to a written plan of care (described earlier): nursing care provided by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services under the direction of a physician; services of a home health aide who has successfully completed an approved training program; medical supplies including drugs and biologicals, and the use of medical appliances while under such a plan; physicians' services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting conditions determined by the Secretary to be appropriate; and counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his or her death.

The bill provides that reimbursement for services in the case of hospice care shall be limited to those services which are reasonable and necessary for the palliation and management of terminal illness. This restriction pertains to all aspects of the hospice benefit, including the provisions relating to comfort items, custodial care, and medical supplies (including drugs, and biologicals) and the use of medical appliances.

The bill provides that the nursing care, home health aide, and homemaker services described above may be provided on a 24-hour continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

The term hospice program is defined to mean a public agency or private organization (or subdivision thereof) which is primarily engaged in providing the care and services described above (and making them available, as needed, on a 24-hour basis), and which also provides for care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice, except that the hospice must routinely provide directly (or under arrangements with other hospice programs) substantially all of the following core services: nursing care provided by or under the supervision of a registered professional nurse; medical social services under the direction of a physician; physicians' services; short-term inpatient care in the hospice's owned or leased inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care; and counseling (including dietary counseling) with respect to care for the terminally ill individual and adjustments to his or her death.

The hospice program must also provide bereavement counseling for the immediate family of the terminally ill medicare beneficiary. Bereavement counseling for family members is an important aspect of hospice care. It was felt, however, that reimbursement for such services, for other than the beneficiary, was inappropriate under the medicare program. The provision would require that bereavement counseling be provided to the immediate family of the beneficiary, but such services would not be a reimbursable cost under the hospice benefit.

It is the intent of this provision to ensure that hospices provide a basic and coordinated range of services (rather than allowing them to be a provider that merely subcontracts for services) while giving hospices the flexibility to provide, under arrangement, for some services (such as speech therapy) which may be needed infrequently, or to allow hospices to arrange, for example, for a temporary nurse, if the hospice has an unusually high case load.

This provision would require that hospices provide directly and routinely (through their own inpatient unit or through leased facilities, or under arrangement with another hospice program), substantially all short-term inpatient care. It is not the intention of this provision to require hospices to have their own inpatient facility; the building of additional bed capacity, especially in overbedded areas is to be avoided. The intent is to allow hospices which do not have their own inpatient facility to lease from an inpatient facility, meeting such conditions as the Secretary determines to be appropriate, some beds in a unit—for example, a wing, floor or group of rooms. However, the hospice would be directly responsible: for providing professional supervision over care provided to the medicare beneficiaries in this unit; for maintaining central records; and for the costs incurred by those beneficiaries during their inpatient stay.

For example, if a hospice leased a unit within a hospital (as the hospice inpatient unit), the intent is that the hospice would retain responsibility for the provision and cost of such care, that the care provided be consistent with the hospice concept of care through the delivery of care or supervision of such care by an interdisciplinary group, and that the treatment provided be reasonable and neces-

sary for the palliation and management of terminal illness. It is expected that if the hospital, in this example, routinely required certain medical tests on admission to the hospital, such tests would not be required for hospice beneficiaries in the hospice unit if such tests were inconsistent with the written plan of care established for the patient and if they were not necessary for the palliation and management of terminal illness.

The hospice program would be required to provide assurances, satisfactory to the Secretary, that the aggregate number of days of inpatient care provided in any 12-month period to individuals electing that particular hospice program, will not exceed 20 percent of the aggregate number of days during that 12-month period on which such elections for such individuals are in effect.

This limit on aggregate numbers of inpatient days is consistent with the pattern of development of hospices in the United States, which has emphasized caring for the patient in the home. It is not the intention to encourage more inpatient care than is now generally being provided, especially in light of the significantly higher costs of providing care in the inpatient setting.

The provision requires a hospice program to have an interdisciplinary group of personnel which includes at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor employed by the agency or organization. The provision requires that the interdisciplinary group provide the hospice care and services described above and establish the policies governing the provision of such care and services.

The provision requires that the hospice maintain central clinical records on all of its patients.

The bill provides that if a medicare beneficiary uses up his entire hospice benefit, and thus would not receive any further medicare reimbursement, the hospice may not discontinue care to that beneficiary and may not charge the beneficiary for the additional services. The intent is to ensure that the hospice will not discontinue or significantly diminish the care it provides to the beneficiary once he or she has exhausted his or her medicare benefits under this provision.

The hospice program is required to routinely utilize volunteers in its provision of care and services to a significant extent and at a level not lower than that in effect before the date of enactment of this provision. In addition, the hospice must maintain records of the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers. It is anticipated that hospices would supplement the care given by paid nursing staff and other medical personnel with active volunteers who work directly with patients and their family members both in the patients' home and the inpatient setting.

It is recognized that use of volunteers is fundamental to the hospice concept and an element upon which estimated cost savings are based. It is the intention that the extension of the hospice benefit and resulting medicare reimbursement to hospice providers not detract in any way from the voluntary spirit of hospice programs. Hospices currently use unpaid volunteers to fulfill both direct care functions and to provide assistance in the ancilliary, office and fundraising activities of hospice programs. Hospice volunteers, in

96-955 O - 82 - 4

addition to providing professional services to patients, also help patients and families with household chores, shopping, transportation, and provide on-site companionship. These services have the effect of helping patients stay at home instead of in an institution.

It is intended, therefore, that the Secretary shall monitor the relationship of total volunteer hours to total enrolled days and shall indicate, to any individual hospice when he or she perceives any substantial diminution in the proportion of volunteer participation. The Secretary is further required to examine the use of volunteers in the hospice setting and to establish minimum participation requirements for volunteers in both new and existing hospices.

The bill provides that the Health Care Financing Administration's hospice demonstration projects, shall continue until August 1, 1983 or, if later, the date on which payments can first be made under this provision.

The provisions of the bill would become effective on August 1, 1983. As hospice is a relatively new concept and because the experience of specific hospice programs is limited, the bill includes a provision which would require that the hospice benefit be discontinued beginning October 1, 1986, unless Congress passed legislation to continue the benefit.

Section 102: Coverage of extended care services without regard to 3-day prior hospitalization requirement

Present Law

Current medicare law provides coverage of up to 100 days of "post-hospital extended care services" in a qualified skilled nursing facility following a hospital stay by the beneficiary of at least 3 days. This coverage was provided to encourage convalescence in a skilled nursing facility following hospital treatment, where medically appropriate, as an alternative to the continued occupancy of a high-cost acute hospital bed.

The 3-day prior hospital stay requirement has been criticized by some as an unnecessary and unfair barrier which inhibits beneficiaries from obtaining coverage for the appropriate level of care. Critics of the requirement charge that its effect is to have beneficiaries routinely admitted to the hospital for otherwise unnecessary stays in order to qualify for skilled nursing facility care.

In response to these complaints, Congress included in the 1972 Medicare Amendments (Section 222 of P.L. 92-603) authority for the Secretary of Health and Human Services, among other things, to conduct studies and engage in experiments to determine the effects of eliminating or reducing the 3-day stay requirement.

In 1977, the Health Care Financing Administration (HCFA) established 3-year demonstration projects in Massachusetts and Oregon to investigate the consequences of eliminating the requirement. HCFA received an evaluation of the project in September 1981 from a private firm with which it had contracted which indicated that there would probably be no appreciable net increase in program expenditures if beneficiaries were allowed to enter directly skilled nursing facilities.

At a hearing of the Subcommittee on Health of the Committee on Ways and Means on February 2, 1982 regarding medicare cover-

age and reimbursement for skilled nursing facility services, a spokesperson for HCFA testified that a review of the initial evaluation by the Department's Office of Financial and Actuarial Analysis concluded that it was incomplete and that the elimination of the requirement would result in a substantial increase in program expenditures.

Explanation of Provision

The bill would authorize the Secretary of Health and Human Services to provide for coverage of extended care services which are not post-hospital services only when he has determined that the inclusion of such services will not result in any increase in program expenditures and will not alter the acute care nature of the skilled nursing care benefit.

The Secretary may provide for such limitations on the scope and extent of services that are not post-hospital extended care services and on the categories of individuals who are entitled to such services, and may provide for any restrictions and alternatives on the amounts and methods of reimbursement for such services as he deems necessary to implement the provisions. It is to be understood, however, that any such change which represents an increase in beneficiary out-of-pocket expenses or a diminution of services and benefits would be applicable only to those beneficiaries who directly enter the extended care facility.

Section 103: Medicare coverage of and application of hospital insurance tax to Federal employment

Present Law

Under present law, entitlement to protection under the hospital insurance (part A) portion of the medicare program for most individuals is linked to entitlement to monthly social security retirement, survivor, or disability benefits or to monthly benefits under the railroad retirement system. This entitlement is earned through work in employment covered by the social security or railroad retirement systems. Workers and employers finance the cost of hospital insurance benefits by payment of the hospital insurance tax (2.6% divided equally between worker and employer in calendar 1983) on wages subject to social security taxation ($35,100 in calendar 1983). Present law excludes certain kinds of employment from coverage under the social security system, including Federal civilian employment that is covered under a staff retirement system established by law. Regular Federal employees, including postal workers, are covered under such retirement systems. Consequently, they pay no hospital insurance taxes, nor is their federal employment used in determining entitlement to hospital insurance.

Explanation of Provision

A significant number of Federal employees and retirees qualify for medicare benefits either on the basis of their own employment outside the Federal government or on the employment of a spouse. As a general rule, Federal employees who qualify for medicare do so on the basis of fewer quarters of coverage than other benefici-

aries. It is believed that Federal employees (and the Federal government, as their employer) should bear a more equitable share of the cost of financing the health benefits to which many of them eventually become entitled.

The bill would subject Federal employment, including employment in the Postal Service, to the hospital insurance tax. Individuals who have been Federal employees and who reach age 65, who suffer from end-stage renal disease, or who become disabled would become entitled to medicare hospital insurance after paying hospital insurance taxes for the same number of years (usually 10) that is required of most other workers and after meeting the same requirements applicable to other individuals.

Individuals who are in the employ of the Federal Government both during and before January 1983 and who would qualify for hospital insurance benefits but for the failure to include Federal employment before January 1983 within the meaning of the term employment for purposes of Title II, shall have their Federal employment before January 1983 considered as "employment" for the purpose of providing entitlement to Hospital Insurance benefits but only with respect to the minimum number of quarters of coverage required for the individual to be so entitled.

The provision would become effective on January 1, 1983.

Subtitle B—Reimbursement and Payment Changes

Section 111: Payment for inpatient hospital services

Present Law

Under present law and regulations, medicare reimburses hospitals (as well as skilled nursing facilities and home health agencies) on the basis of the "reasonable costs" they incur in providing covered services to beneficiaries, excluding any part of such costs found to be unnecessary in the efficient delivery of needed services. Reimbursement for hospital routine operating costs (i.e., bed, board and routine nursing care) may not exceed a limit (known as the Section 223 limit) based on similar costs incurred by comparably situated hospitals in an area. Under this limitation, a hospital may not be reimbursed for more than 108 percent of the average routine cost per day incurred by other hospitals of the same type in an area, unless it qualifies for an exception or an exemption.

In brief, the calculation of the Section 223 limit involves: identifying the inpatient general routine operating cost for each hospital, adjusted for certain factors including an area wage adjustment; calculating the mean (average) of the adjusted routine operating costs of the comparable hospitals in a group; applying the reimbursement limit (currently 108 percent) to the mean to establish a limit for each hospital grouping; and making certain adjustments to the limits when applied to individual hospitals. Inpatient routine per diem costs in excess of the applicable limits are not reimbursable by the medicare program. If a hospital's allowable per diem costs are under the Section 223 limits, the facility is reimbursed for its reasonable costs.

The existing medicare reimbursement system for providers of service is generally based upon retrospectively determined costs,

rather than on any system in which payment rates or amounts are determined prospectively.

Explanation of Provision

Hospital spending has been increasing at double-digit rates for over a decade and much faster than the rates of inflation in the economy as a whole. Hospital spending accounts for over 70 percent of medicare program expenditures, and the persistently large increases in hospital costs are now threatening the financial soundness of the hospital insurance trust fund.

The bill addresses the problem of medicare program spending for hospital care in several ways: (a) by expanding the existing Section 223 limits on inpatient general routine per diem operating costs to hospital ancillary operating costs and special care unit operating costs as well, thereby establishing an overall limit on hospital inpatient operating costs per case; (b) by giving hospitals, under a temporary 3-year provision, a medicare target reimbursement rate of increase aimed at providing an incentive to control costs; (c) by directing the Secretary of HHS to develop a specific plan under which hospitals and skilled nursing facilities would be paid on the basis of prospectively established rates, and providing for this new payment methodology to go into effect unless disapproved by both Houses of Congress; and (d) by permitting medicare reimbursement to be made under terms of a hospital cost control system in a State if the Secretary finds that doing so would result in medicare payments no greater than would overwise have been paid.

a. Expansion of Section 223 limits to include ancillary costs.—The provision modifies the existing section 223 limits by: (1) exempting from the limits currently existing small hospitals (which were in operation and had less than 50 beds on the date of enactment); (2) extending the limits to include hospital ancillary operating costs (e.g. lab services, X-rays, drugs, etc.) and special care unit operating costs; (3) increasing the current limit from 108 percent to 120 percent beginning with fiscal 1983, but permitting the Secretary to establish lower limits thereafter (not lower than 115 percent for fiscal year 1984 and not lower than 110 percent for fiscal year 1985); (4) applying the limit on an average operating cost-per-case basis; (5) adjusting the limits as the Secretary deems appropriate to take account of the special needs of psychiatric hospitals and the special needs of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to medicare hospital benefits; and (6) adjusting each facility's limit to take into account the needs of its particular patients compared to the needs of patients in other hospitals with which it is being compared (by making "case-mix" adjustments).

The Secretary is expected to recalculate case-mix adjustments periodically. It is understood that initially the Secretary will need to rely on a currently available indicator of case-mix complexity such as the system developed at Yale University. It is expected that the Secretary will continue to evaluate possible methods for adjusting for case-mix and will adopt an improved method when it becomes available.

The limits will be applied to total inpatient operating costs per case, rather than inpatient routine operating costs per diem. By including ancillary and special care unit operating costs under the section 223 limits, it will be possible to look at overall costs involved in caring for medicare patients and to determine payment on a per case rather than per-day basis, thereby removing any incentives to keep patients longer than absolutely necessary. It is believed that information on costs of care made available by the new system of limits will assist in the development of a prospective payment system.

In no case would a hospital's reimbursable cost per case be reduced below the per case costs that were reimbursable by medicare for the hospital's last full cost accounting period prior to the first cost accounting period (or portion thereof) for which the revised system of limits is applicable.

It is expected that in most other respects the current methods used to develop limits on routine operating costs will form the basis for initial application of the new limits, e.g., hospitals will continue to be classified into comparison groups and factors such as area wage differences will be recognized.

It is expected that historical cost data, updated to reflect average actual cost increases, would be used to develop the cost limits, except that in projecting anticipated cost increases for the accounting period to which the current limit is being applied, the measure used will be a marketbasket measure of the prices paid by hospitals for supplies and services.

The Secretary would be authorized to provide for such exemptions, exceptions, and adjustments to the limits as he deems appropriate. In general, it is expected that the Secretary will continue to provide for the same exemptions, exceptions, and adjustments as are currently allowed under the existing section 223 limits, to the extent that he finds them to be appropriate under the new methodology for establishing reimbursement limits. These would include, for example, adjustments for medical education costs; exceptions for such things as atypical services, extraordinary circumstances (flood, fire, etc.), fluctuating population, medical and paramedical education, essential community services, and unusual labor costs; and exemptions for sole community hospitals, for new providers, and for services provided by risk-based HMOs.

The Secretary is expected to consider the adoption of such new exemptions, exceptions, and adjustments as may be appropriate under the new system of limits, including an adjustment for changes in case-mix caused by significant changes in a hospital's operation or organization (e.g., the addition of a new service).

In addition, it is important that the Secretary make downward adjustments where appropriate to assure that the limits are not significantly compromised and that they actually operate as intended, for example, where there is a significant change in a hospital's case-mix or where the hospital has cut back on the kinds of services it provides directly to its patients—e.g., by leasing out its clinical laboratory.

Hospitals have expressed a number of concerns about the exceptions process under the existing section 223 limits, including an apparent lack of uniformity in the granting of exceptions (and exemp-

tions, in the case of sole community providers), and lack of clarity regarding the specific criteria for exceptions and exemptions. They also argue that the unavailability of data about the performance of hospitals that are classified as peers prevents them from determining their relative status and the possible legitimacy of an exception in an individual case. The Secretary is urged to require uniformity in the granting of exceptions and exemptions, to establish exceptions criteria as specific as possible, and to make available to hospitals, to the extent possible, data on the characteristics of hospitals in comparison groups.

The provision would be effective October 1, 1982, except that any change in the amount of payments resulting from the new limit would be effected only in proportion to the part of a hospital's accounting period that occurs after September 30, 1982. Similarly, where the authority granted the Secretary to lower the limits may be exercised no earlier than October 1 of 1983, 1984, and 1985, the Secretary may establish the limits as of October 1 or such later date as he determines, but the change in the amount of payments would be effected only in proportion to the part of a hospital's accounting period that occurs after September 30 or such later date.

b. Transitional 3-year incentive payment system.—The existing hospital reimbursement arrangements under medicare provide no direct incentive for hospitals to constrain their costs, other than such incentive as is provided by disallowance of costs that exceed currently applicable reimbursement limits. As indicated below, it is anticipated that in the near future a new system of medicare prospective payments for hospitals and skilled nursing facilities will be adopted. Nonetheless, it is desirable to put into place, until such a prospective payment system takes effect, but in no event for more than 3 years, a transitional incentive payment system intended to provide a direct incentive for hospitals to control their costs.

The new incentive payment system would operate concurrently with the revised system of limits described in (a) above. The payment amount determined under the incentive system would be the amount actually payable to a hospital, except to the extent that it exceeded the amount payable under the revised system of limits described in (a) above.

Under the provision, each hospital would be given a medicare target payment rate of increase, applied to average inpatient costs per case, over the hospital's preceding cost accounting period. For the first accounting period, or portion thereof, to which the provisions applies, the target amount to which the rate of increase would be applied would be the hospital's medicare allowable cost per case for the preceding 12-month accounting period. In determining the target amount for subsequent accounting periods, the target rate of increase would be determined in relation to the target amount for the preceding 12-month accounting period (thus, a hospital would not in effect be penalized for having kept its actual costs low in the preceding accounting period).

Actual payments to hospitals would be determined in relation to the target amount. Hospitals with costs below the target would be paid 50 percent of the difference between their costs and the target amount, up to a maximum of 5 percent of their target amount. Hospitals with costs above the target would be paid the target

amount, plus: (a) 50 percent of their costs that are up to 105 percent above the target amount; (b) 25 percent of their costs that are between 105 and 110 percent above the target amount; and (c) none of their costs that exceed 110 percent of the target amount.

The annual percentage increase used in determining the target amount would be established by the Secretary and would consist of one percentage point plus the rate of increase in a marketbasket measure of the prices paid by hospitals for supplies and services. (CBO is currently projecting the marketbasket increase at 8.7 percent in fiscal year 1983, 8.4 percent in fiscal year 1984 and 7.9 percent in fiscal year 1985.)

The Secretary would be required to provide for such adjustment to the payment amount determined under the incentive payment provisions as he deems appropriate to take into account the special needs of psychiatric hospitals.

The Secretary would be authorized to provide for such exceptions and adjustments (having the effect of either increasing or decreasing the target payment amount) as he deems appropriate. The principal intention in authorizing such adjustments is to take into account factors that would distort either a hopital's base period or rate of cost increase during the 3-year period to which the incentive payment provisions are applicable. Examples of such factors include significant changes in a hospital's case-mix in a particular year when compared to the base year, extraordinary circumstances beyond the hospital's control, and a reduction in a hospital's costs resulting from cutting back on the kinds of services directly provided to patients—e.g., as the result of leasing out its clinical laboratory.

Because the proposed target rates of increase and the new section 223 limits would be determined on a per admission or per discharge basis, an incentive would be created to increase admissions or discharges. It is anticipated that the Secretary will give consideration to means of limiting artificial increases in admission or discharges.

The incentive payment provisions would be effective from October 1, 1982 through September 30, 1985, except that the provisions would cease to apply as of the time a prospective payment system, discussed below, becomes effective with respect to a hospital's cost accounting year or portion thereof. In the case of a hospital cost accounting period beginning before October 1, 1982, or ending after September 30, 1985, the change in the amount of payments resulting from adoption of the incentive payment provisions would be applied only in proportion to the part of the accounting period that occurs after September 30, 1982, or before October 1, 1985. Because the incentive payment provisions apply in some instances to partial accounting years, it is expected that the Secretary will make appropriate adjustments as needed, e.g., to the target reimbursement rate and to the percentage increase in the hospital marketbasket, to reflect the partial accounting years involved.

c. Prospective payment system for hospitals and skilled nursing facilities.—The incentive payment provisions of the bill would begin the process of changing medicare reimbursement provisions so that they no longer simply make payments on the basis of retrospectively determined costs. It is time to move promptly to a pros-

pective payment system that more directly rewards hospitals and skilled nursing facilities for efficiency and cost control and that enchances their financial planning ability by establishing a methodology under which rates or amounts to be paid during a specified period are established prior to the defined rate period.

The bill would therefore direct the Secretary to develop such a prospective payment plan for inpatient hosptial services and extended care services and submit it to the Congress not later than December 31. 1982. The plan is to be designed to take effect on October 1, 1983, and to result in medicare payment amounts for such services that are not in excess of the amounts which the Secretary estimates would have been made in the absence of the plan. If the plan is submitted to the Congress on a timely basis, it would automatically take effect on October 1, 1983, unless the Congress adopts, not later than July 1, 1983, a concurrent resolution disapproving the implementation of the plan.

The prospective payment plan developed by the Secretary must be designed to apply to at least inpatient hospital services and extended care services, but may also include within its scope outpatient hospital services and services furnished by other providers of services. However, the provisions of the plan applicable to these latter services, if included, would not automatically be implemented in the absence of disapproval by the Congress. It is expected that the plan developed by the Secretary will be sufficiently detailed to implement in the form submitted, and expects that the Secretary will include such provisions as he deems appropriate relating to exemptions, exclusions, and adjustments of payment amounts.

d. Recognition of hospital cost control systems in a State.—The bill would permit medicare reimbursement to be based upon the reimbursement control system in a State if the Secretary of HHS is satisfied that, over a three-year period, it would result in medicare payments no greater than would otherwise have been paid. The Secretary would be authorized, at his discretion, to permit payment under an alternative reimbursement system if, upon application by the State, the Secretary determined that (1) the system would apply to substantially all non-Federal acute care hospitals in the State and would apply to the review of at least 75 percent of all revenues or expenses for inpatient hospital services including medicare and medicaid; (2) the Secretary has been provided satisfactory assurances regarding the equitable treatment of all entities that pay hospitals for inpatient services (including medicare and medicaid), together with assurances regarding the equitable treatment of hospital employees and patients; and (3) the Secretary has been provided satisfactory assurances that under the system, over a 36-month period, the amount of payments made under the proposed alternative reimbursement system would not be greater than the amount of payments which would otherwise have been made under medicare.

Several States presently have reimbursement systems which have resulted in a reduced rate of increase in medicare expenditures. Thus, in determining whether an alternative system would result in reimbursement which is less than otherwise would have been paid in a State, the Secretary would be permitted to take into

96-955 O - 82 - 5

account previous reductions in medicare reimbursement due to the operation of a hospital reimbursement control system if such system has resulted in an aggregate rate of increase in operating costs of inpatient services under medicare which was less than the national aggregate rate of increase in such costs.

As noted above, an alternative payment system would be required to cover substantially all nonfederal acute care hospitals in a State. It is intended that, where a statewide system includes a voluntary agreement as part of its methodology, and where individual hospitals select not to accept that methodology, the Secretary would be permitted to pay such hospitals according to medicare's national payment system. In such a case, Federal payments to such hospitals would be considered in evaluating the success of the alternative system.

It is intended that the Secretary would be permitted to approve payments under an alternative payment system which used methods of payment and standards of reasonableness similar to those established by Federal law because it is believed that such methods of payments and standards are useful and reasonable in reducing rates of increase in hospital costs.

The Secretary would be authorized to discontinue payment under the alternative system if he determines that the requirements were no longer being met. In the case of a determination regarding the projected effectiveness of the reimbursement system; over a three-year period, the Secretary would be permitted to discontinue payments during such three-year period if he was reasonably certain that such projections would not be met.

The provisions of current law with respect to reimbursement demonstration projects (section 402 of the Social Security Amendments of 1967 and Section 222 of the Social Security Amendments of 1972) as well as the provisions permitting the continuation of such demonstrations if certain conditions are met (Section 1814(b)(3) of the Social Security Act) would remain in effect.

Section 112: Optional alternative medicare program (medicare vouchers)

Present Law

The existing medicare program provides a fixed package of benefits, covering services for specified durations, subject to specified deductible and coinsurance amounts.

In general, under part A of the program, payment is made on the basis of reasonable costs, and, under part B, payment is made directly to the beneficiary (or to a physician or supplier who accepts "assignment") for services reimbursable on the basis of reasonable charges.

There is no opportunity for beneficiaries to choose an alternate package of benefits, nor is there opportunity for the beneficiaries to use the actuarial value of their medicare protection to purchase protection under a privately sponsored health benefit plan.

Explanation of Provision

The bill would establish a medicare voucher system under which persons eligible for medicare benefits could elect to receive a medicare voucher in lieu of receiving benefits under the regular medicare program. At the beneficiary's option, the voluntary voucher would be applied toward the purchase of a qualified health care plan.

Persons eligible for the voucher would be aged and disabled persons entitled to benefits under, or enrolled in, parts A or B of medicare and who are not medicaid eligible individuals. Persons suffering from end-stage renal disease would not be eligible unless they were aged or disabled individuals.

The amount of the voucher would be based upon the average expenditure per medicare beneficiary in 1982 in a health care area, increased or decreased annually by the same percentage as the percentage increase or decrease in the medical care component of the Consumer Price Index. If an individual elected to enroll in a qualified health plan, the plan would receive from the Secretary the voucher amount adjusted for certain actuarial categories. The Secretary would establish actuarial categories to take into account age, sex, disability status and other factors which the Secretary determines appropriate. The actuarial adjustment would not affect the amount of benefits to which an individual was entitled and would be used only for purposes of determining the amount to be paid to the qualified plan.

The Secretary would be required to notify annually each eligible individual of his or her right to elect the voucher, to change qualified health plans, or to revoke the election. The Secretary would be authorized to distribute information which would assist individuals in choosing plans. In addition, the Secretary would be required to announce, prior to October 1 of each year, the amount of the voucher for eligible individuals in each health care area for the following plan year.

An individual would be permitted to elect, change or revoke his or her enrollment in a qualified plan during the general enrollment period in November of each year. If an individual revoked an election for a plan and did not choose another qualified plan, the individual would automatically receive benefits under the regular medicare program at the beginning of the next plan year. If a plan ceased to operate during the plan year, individuals receiving benefits under that plan would be permitted to choose another plan or resume receiving regular medicare benefits.

To become a qualified health care plan, a plan would be required to provide at least those health care services which are covered under parts A and B of medicare. The qualified plan would be permitted to provide services directly to beneficiaries, as in the case of a health maintenance organization, or to pay others for the delivery of the services, as insurance plans pay for hospital and physician services. With certain exceptions, a plan would be permitted to specify the plan deliverers at which, or from whom, a member of the plan would be required to receive services.

The plan would be required to accept all eligible individuals residing in the health care area with certain exceptions. A plan

would be permitted to limit the number of persons it would enroll for a plan year only if it had notified the Secretary and the general public prior to the enrollment period for that year. Further, the plan could only apply such a limit to the total number of persons enrolled and not to any particular category of members.

Under the bill, a plan would be permitted to limit the number of medically high-risk individuals where the Secretary determined that a limit was necessary to prevent a disproportionate share of high-risk persons from becoming members of the plan. In addition, a plan would be permitted to deny membership to persons it reasonably believed were not financially capable of paying the plan premium or out-of-pocket expenses and to disenroll members who did not pay within a specified time period. Those members disenrolled because of nonpayment would be permitted to return to the regular medicare program.

The bill provides that out-of-pocket expenses under the plan could not exceed the average out-of-pocket expenses under the current medicare program. The Secretary would establish a maximum financial participation amount based upon the average deductible and coinsurance amounts under part A for 1982, plus the part B deductible and a computation representing coinsurance under part B. This amount would be indexed annually by the percentage increase or decrease in the medical care component of the CPI.

As long as a plan covered at least those services provided under parts A and B and did not result in out-of-pocket expenses in excess of the maximum, the scope and coverage of the plan could vary. However, with respect to a plan meeting these requirements, premiums for all eligible individuals could not vary. Further, plans would be prohibited from making distinctions based upon age, sex, health or disability status, or prior utilization of health services.

Where a beneficiary chooses a plan for which the premium is less than the voucher amount to which individuals are entitled under the program, the beneficiary would receive a rebate of one-half of the difference between the premium and the voucher amount, not to exceed $500 in one year. The remaining one-half would be returned to the medicare trust fund. The rebate, which would not be subject to Federal income tax, could be provided as either a cash rebate or as credit toward payment for plan services.

The voucher system would become effective only at such time as the Secretary of Health and Human Services is reasonably certain that the methodology to assure actuarial equivalence can be implemented, but not earlier than January 1, 1984.

Section 113: Payments to health maintenance organizations

Present Law

Health Maintenance Organizations (HMOs) are reimbursed by the medicare program for services covered under both parts A and B of medicare according to the authority established in section 1876 of the Social Security Act.

Under section 1876, HMOs receive interim monthly capitation payments for services furnished to medicare beneficiaries according to one of two types of contracts, cost or risk. HMOs which are paid under cost contracts are reimbursed for the reasonable costs of pro-

viding covered services to medicare enrollees according to medicare's principles of cost reimbursement.

Under risk contracts, reimbursement is based on a comparison of the HMO's costs with its Adjusted Average Per Capita Cost (AAPCC), which is the average cost of providing services to medicare beneficiaries in the same geographic area as the HMO but not enrolled in the HMO and having the same characteristics as the medicare population.

Only one HMO has opted to be reimbursed under the existing risk formula. HMOs have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. It is recognized that HMOs, in the non-medicare portion of their business, receive a fixed, prospectively determined payment per enrollee which is not related to the amount of care provided. This payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and to provide the least expensive service appropriate to the enrollee's needs. These incentives are passed on to the physician by paying him on a salary basis, providing a bonus or profit sharing arrangement when costs are kept low, or providing other meaningful incentives for him to control costs and utilization.

Explanation of Provision

Under the provision, medicare payment to HMO's under a risk contract would be based on a prospectively determined per capita amount per enrollee to be set at 95 percent of the per capita amount that would be paid by medicare for services provided to an enrolled beneficiary (classified by actuarial factors such as age) by other providers in the geographic area of the HMO. For example, the rate of payment for a 65 year old beneficiary would be lower than the rate for an 85 year old beneficiary.

It is understood that the Secretary needs broad discretion in selecting actuarial factors which are appropriate for this purpose. Nevertheless, it is expected that the Secretary will carefully evaluate the validity of every factor he proposes to use. It is intended that eligibility for cash benefits under the Disability Insurance program or under SSI may be used as an indicator of disability status, along with factors, as he/she deems appropriate for making such adjustments. The use of any actuarial factor does not, and should not, affect in any way the benefits or the out-of-pocket expenses (deductibles and co-insurance) of medicare beneficiaries or their opportunity to enroll in an HMO.

In addition, the risk reimbursement formula requires the HMO to provide to enrolled medicare beneficiaries increased benefits or reduced cost-sharing, to the extent that the medicare reimbursement exceeds the HMO's adjusted community rate (discussed below). This approach would create incentives for medicare beneficiaries to enroll in HMO's and assure that the economies realized through HMO efficiencies, in excess of the HMO's usual profit and other retained funds, accrue to beneficiaries. The HMO would determine what additional benefits, reduced beneficiary cost sharing or combination of the two are most appropriate for its

medicare enrollees. The Secretary would be required to report to the Congress three years after implementation of the HMO provision on the type and amount of additional benefits which are being provided. The provision also requires the Secretary to study and report to the Congress the causes for beneficiary disenrollment from HMOs under medicare contracts, paying particular attention to the utilization and quality of services provided these beneficiaries and their medical condition prior to disenrollment.

If an HMO with an existing cost based reimbursement contract elects to enter into a new risk based contract, the medicare beneficiaries enrolled with the HMO at the time the new contract first applies would have an option. They could continue to receive their medical care either inside or outside the HMO and be reimbursed by medicare in the current manner; or they could receive services furnished only by, or through, the HMO (be "locked-in") and have the HMO receive all payments through the new risk contract. The advantage to the beneficiary of being locked-in is that they could then receive the additional benefits offered by the HMO when its adjusted community rate is less than its payment from medicare. If the Secretary found there were administrative costs or other administrative burdens involved in allowing the HMO to be reimbursed under both cost and risk contracts, he or she could require all medicare enrollees to be locked-in.

Where an HMO had a cost based reimbursement contract on the initial effective date of this provision, there would be a limit placed on the number of medicare beneficiaries who were enrolled on the initial effective date who could be reimbursed under the new risk contract. For each two medicare beneficiaries who enroll after the HMO enters into the risk contract, one current enrollee could be included in the risk contract. This conversion formula was included to counteract any increase in outlays to medicare due to the new risk reimbursement.

To mitigate the adverse effect on those medicare enrollees who wish to participate in the risk contract and receive the additional benefits, but cannot because of the conversion formula, an HMO would be allowed to receive cost based reimbursement for them, but share with them, the additional benefits accruing to medicare enrollees under the risk contract. If enrollees with respect to whom cost based reimbursement is made elected to receive additional benefits they would be locked in.

There are some medicare beneficiaries currently locked into HMOs. They are enrolled in the one current risk contract or are participating in one of the several demonstrations of risk based systems. To protect them, the provision would delay the mandatory application of the new risk based contract requirements on those HMOs for five years after the initial effective date, or until the demonstrations are completed. At that time those HMOs would have to choose between cost based or the new risk based reimbursement, if it is in effect. If they select risk, all medicare beneficiaries enrolled under the old risk contract or the demonstrations could enroll under the new risk contract and the conversion formula would not apply.

An HMO would be defined as a public or private organization which is organized under the laws of any state. It would include

both federally qualified HMOs and other HMOs which are constituted in accordance with requirements spelled out in the provision. These requirements were developed so that HMOs which are not federally qualified would be eligible to participate in this new medicare reimbursement system.

An HMO which is not federally qualified must meet several requirements. The organization must provide the following comprehensive range of health care services to enrolled members: physicians' services, inpatient hospital services, laboratory, X-ray, emergency and preventive services and out of area coverage. Preventive health services would include services such as voluntary family planning, well child care, periodic health evaluation for adults and pediatric and adult immunization.

The organization must be compensated (except for deductibles, co-insurance and co-payments) for the provision of health care services to a member by a fixed periodic payment which is unrelated to the frequency, extent, or kind of health care services actually provided to that member.

The organization must provide physician services either (1) directly through physicians who are either employees or partners of the organization, or (2) through contracts with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

If an organization meets the requirements, it would be considered a health maintenance organization for purposes of reimbursement under medicare. In order to participate in medicare, however, it must also meet certain conditions of participation. For example, the HMOs minimum benefit package must include the services to which a medicare beneficiary is entitled under the medicare program. It may include additional health care services at the option of the medicare beneficiary or if the Secretary approves such additional services. The purpose of permitting Secretarial approval of a broader minimum benefit package is to allow an HMO to offer medicare beneficiaries the same minimum benefit package offered non-medicare enrollees. (The HMO could add services to those approved by the Secretary only at the election of the medicare beneficiaries.) If the Secretary determined that including additional services would substantially discourage enrollment by medicare beneficiaries, then the Secretary would not be permitted to approve the addition. Under any circumstance the HMO is required to inform medicare beneficiaries of the portion of their premium rate or other charges which are applicable to any additional services. The HMO must limit the amount of premium or other payments charged to its medicare enrollees for their entitled benefits to the actuarial equivalent of medicare deductibles and coinsurance that would apply to these beneficiaries were they not enrolled in the HMO. Any premium charged and the actuarial value of any deductible, co-insurance or co-payment charged for additional services (described in the preceding paragraph) could not exceed the adjusted community rate for those services.

In order to assure that an HMO makes a genuine effort to enroll medicare beneficiaries, the HMO must have an open enrollment period of reasonable duration at least every year, during which it accepts medicare beneficiaries up to the limits of its capacity and

without restrictions on the order in which they apply for enrollment. This requirement is necessary since most HMOs enroll only groups, and medicare beneficiaries, in many instances, would be enrolling as individuals. Without assurance of open enrollment, such medicare beneficiaries would have no access to the HMO. No HMO, however, would have to accept proportionately more medicare enrollees than are represented in the population in the geographic area served by the HMO.

Federally qualified HMOs must set their premiums under a defined community rating system. Because the definition of HMOs is expanded to include organizations not federally qualified, the bill permits an HMO to develop an adjusted community rate for its medicare beneficiaries based upon its weighted aggregate premium for non-medicare beneficiaries. The adjustment of the weighted aggregate premium is to be made in a manner similar to the adjustment of the community rate of a federally qualified HMO.

Under the bill, the new HMO provision may not be implemented until the Secretary of Health and Human Services notifies the Congress that he is reasonably certain that the methodology to make appropriate adjustments in average adjusted per capita cost (AAPCC) has been developed and can be implemented to assure actuarial equivalence. This provision was added in order to assure that the provision would not increase outlays in the medicare program once implemented.

Section 114: Prohibiting recognition of payments under certain percentage arrangements

Present Law

Existing law specifies that the Secretary, in determining reasonable costs with respect to home health agencies, may generally not include any cost incurred by the home health agency under a contract which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement.

The law does not specifically prohibit recognition of percentage arrangements entered into by other providers such as those involving contracts for support services, including computer and data processing, financal and management consulting, or the furnishing of equipment and supplies. Examples of such arrangements are contracts calling for remuneration to suppliers of the services based on a percentage of the gross or net billings of the health care facilities or of individual departments.

Payments made to a subcontractor by a provider for such services on a percentage basis are subsequently incorporated into the cost base against which medicare makes its payment determinations. Such arrangements can be highly inflationary and add costs to the medicare program which may not reflect actual efforts expended or costs incurred.

In a report to the Health Care Financing Administration, the General Accounting Office has expressed concern about such contracts, noting that at the outset of the contract the total dollar amount of the fee is not known, and that with percentage of gross revenue arrangements, there is no direct incentive to keep costs

down—the incentive is to maximize revenues and thereby the fees received.

Explanation of Provision

Under the bill, where reimbursement to a provider is made on the basis of reasonable costs or on a cost-related basis and where such provider has entered into a contract for the purpose of having services furnished for, or on behalf, of it, any cost incurred under the contract would not be considered reasonable if the amount payable under the contract by the provider is determined on the basis of a percentage (or other proportion) of the provider's reimbursement for services furnished by the provider. It would be applicable, among other arrangements, to percentage arrangements between providers and provider-based physicians.

The provision would not apply, however, under regulations of the Secretary, to certain types of percentage arrangements which are customarily considered normal commercial business practices, such as the commission paid to a salesman. Nor would the provision apply to percentage arrangements which, under regulations, are found to promote the economical operation of the provider of services.

The provision would be effective upon enactment. However, with respect to arrangements entered into prior to the date of enactment, the provision is applicable one year after the date of enactment except in the case of arrangements a provider may unilaterally terminate; for such arrangements, the prohibition applies 30 days after the first date following enactment that the provider of services may terminate the arrangement.

Section 115: Reimbursement of assistants at surgery

Present Law

Under current law and regulations, part B carriers are given discretion for reimbursing assistants at surgery (i.e., physicians who assist the primary surgeon during an operation). Generally speaking, the carriers follow local medical practice and/or private sector reimbursement policies.

Explanation of Provision

Historically, many carriers have allowed assistants at surgery to bill fees (typically 20 percent of the primary surgeon's fee) only in hospitals in which approved residency training programs did not exist in the specialty. The rationale for not permitting assistants at surgery to bill fees in teaching hospitals has been that fully qualified house staff are available to serve in the capacity of assistants at surgery. Hospitals are reimbursed by medicare on a reasonable cost basis for the salaries of such house staff. However, there has been a recent trend for carriers to allow charges for assistants at surgery who are not residents even in situations where a training program exists in that specialty.

The bill would prohibit reasonable charge reimbursement for an assistant at surgery in hospitals where an approved training program exists in the specialty, except under the following exceptional

circumstances: (1) exceptional medical circumstances, including emergency situations; (2) where the service is complex and requires performance by a team of physicians; and (3) where the patient has multiple conditions which require the presence and active care by a physician of another specialty during an operation. The Secretary is directed to define each of these situations more specifically.

The bill prohibits reasonable charge reimbursement only where a qualified individual on the staff is available to provide the services of an assistant at surgery. It is expected that the Secretary, in any determination regarding the availability of a qualified individual, will take into account the actual availability of such an individual with respect to an operation on a specific patient in hospitals with relatively few residents in the medical specialty involved, and the fact that some attending physicians in such hospitals do not involve residents in the care of their patients.

The bill also directs the Secretary to determine appropriate methods of reimbursement for assistants at surgery in situations where the services of such an assistant are reimbursable under part B.

The provision is effective with respect to services performed on or after October 1, 1982.

Section 116: Interest charges on overpayments and underpayments

Present Law

Under current law, providers and suppliers of services who receive overpayments from the medicare program are not charged interest either for the period during which they have use of the money or for the period during which repayment is being made. Similarly, medicare pays no interest on any underpayments it makes to providers.

At present, a provider or supplier who has been determined to have received an overpayment from medicare may repay the debt either through a lump-sum settlement, or, in the case of a hospital which receives reimbursement through periodic interim payments (PIP) or a physician who accepts assignment, by a reduction in their next regular medicare payment, or through installment payments. Regardless of which repayment method is selected, however, no interest is charged on the overpayment. When medicare has been determined to have underpaid a provider or supplier, its normal procedure is to pay the balance in a lump-sum settlement. Here again, however, no interest is charged on the underpayment.

It is believed that the absence of interest charges, especially in the case of installment payments, may encourage providers and suppliers to place a low priority on the payment of their debts to the medicare program. Moreover, it seems inappropriate for providers to have interest free use of medicare program funds until the overpayment has been repaid.

Explanation of Provision

The bill would require that once a final determination is made that a provider or supplier has received an overpayment or underpayment from medicare, and payment of the excess or deficit is not

made within 30 days of the date of the determination, interest charges would be applied to the balance due.

The rate of interest charged would be estimated by the Secretary of Health and Human Services to equal the average of the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the 3 month period ending with the month before the month in which the final determination is made.

The provision would become effective with respect to final determinations made on or after the date of the enactment of this Act.

Section 117: Prohibiting payment for Hill-Burton free care

Present Law

In reimbursing hospitals and skilled nursing facilities for inpatient services, the medicare program pays only for the necessary costs of efficiently delivering covered services to eligible beneficiaries. Title XVIII expressly prohibits payment for the costs of delivering services to persons who are not covered by the program, including individuals covered by private insurance, individuals eligible for medicaid, and individuals with no public or private coverage.

Under Title VI and XVI of the Public Health Service Act, commonly known as the Hill-Burton Act, the Federal government has made grants, loans, and loan guarantees available to hospitals, skilled nursing facilities, and other health care facilities for construction and modernization projects. In exchange for these Federal subsidies, the Hill-Burton Act requires, and the facilities assure, that they will provide a reasonable volume of uncompensated service to persons unable to pay. This "free care" obligation is voluntarily undertaken by facilities as a condition of receiving Hill-Burton funds.

Explanation of Provision

The bill provides that the Secretary shall, by regulation, provide that the costs incurred by a hospital or skilled nursing facility in complying with its obligation under Title VI or XVI of the Public Health Service Act to provide a reasonable volume of services to persons unable to pay therefore shall not be allowed as a reasonable cost for medicare reimbursement purposes.

The intended beneficiaries of the "free care" provision of the Hill-Burton Act are indigent patients who have no medicare or medicaid coverage and no private health insurance coverage. Since these individuals are not covered by medicare, the program will not recognize as reasonable the costs of a hospital or SNF in delivering services to such individuals.

This clarification is necessitated by a recent decision of the U.S. Court of Appeals for the Fifth Circuit holding that free care expenses incurred by a hospital in connection with its obligations under the Hill-Burton Act are reasonable costs of providing care to medicare patients and therefore reimbursable. Pursuant to the court decision, HHS is now reimbursing for such care with respect to providers located in the Fifth Circuit (Texas, Louisiana, and Mis-

sissippi). The bill would make it clear that the costs of such care are not reimbursable under medicare.

The provision would be effective for services furnished on or after the date of enactment. It is expected that the Secretary would promptly notify intermediaries of the changes made by this provision.

Section 118: Prohibiting payment for anti-unionization activities

Present Law

Hospitals and other providers of service under part A are reimbursed based upon the reasonable cost of providing services to medicare beneficiaries. The Secretary of Health and Human Services is required to promulgate regulations determining which costs are reimbursable. These "allowable costs" are reimbursed based on a hospital's actual costs to the extent they are reasonable and related to patient care. Prior to 1982, the Secretary of HHS had excluded from "allowable costs" the costs incurred by providers for the purpose of persuading their employees not to form a collective bargaining unit or not to join a trade union because such costs were not related to patient care. In January, 1982, the Secretary reversed the earlier policy.

Explanation of Provision

The provision would prohibit medicare reimbursement for costs incurred for activities directly related to influencing employees respecting proposed unionization. Thus, costs incurred for activities related to influencing employees regarding their right to organize, to form a union, or to join a union would not be considered reasonable. Such costs would not be allowable whether performed directly by the provider or through contracts with consultants or attorneys.

The provision would apply to costs incurred on or after the date of enactment. The Secretary is expected to notify intermediaries promptly of the changes in reimbursement made by this provision. Further, to assist intermediaries in determining a hospital's reimbursement, the Secretary is expected to provide for the inclusion in medicare cost reports of an item with respect to such costs.

Section 119: Eliminating of lesser of cost or charge provisions

Present Law

Although medicare providers of services are generally reimbursed, under present law, on the basis of reasonable costs, the amount of payment is limited to the lesser of the reasonable cost of covered services or the provider's customary charges to the public for such services. A variation of this rule applies to "public" (i.e., governmental) providers of services who render services free of charge or at nominal charges to the public; such providers are reimbursed, pursuant to regulations of the Secretary of HHS, on a basis that provides fair compensation. The rationale for this lesser of cost or charges provision was that it would be inequitable for medicare to pay more for services than the provider charges the general public. However, it has been argued that the provision does

not in application appropriately perform its intended function of avoiding excessive payment by the program, and that in some situations it may have the effect of increasing program costs.

Explanation of Provision

Under the bill, the lesser of cost or charges provisions would not apply in the case of services provided by a class of providers of services if the Secretary, in his discretion, determines and certifies to the Congress that the elimination of the provision will not increase medicare payments for services provided by the class of providers.

The change in reimbursement policy would take effect with respect to services furnished, or cost accounting periods of providers, on or after such date as the Secretary provides in his certification to the Congress.

Section 120: Temporary delay in periodic interim payments

Present Law

Under present reimbursement arrangements, hospitals may receive payments for services provided to medicare beneficiaries under one of two different procedures. One arrangement is for hospitals to submit bills and receive payments on the basis of those bills. The average time-lag between the date of service and the date of payment under this procedure is six weeks. Alternatively, hospitals may elect to be reimbursed through periodic interim payments (PIP), which are not directly tied to the receipt of bills. On the average, this procedure produces a three week lag between the rendering of services and the receipt of payment.

Explanation of Provision

The bill would change the periodic interim payment procedure by providing for a delay in the flow of PIP payments in September of 1983 and 1984, so that the lag for payments to hospitals that elect this procedure will increase to about six weeks during the temporary delay. The deferred payments would be paid in October 1983 and 1984.

It is recognized that this adjustment in the normal payment arrangement may be inconvenient for hospitals with limited working capital. To minimize hardship to hospitals affected by the proposal, it is expected that the reimbursement amounts that have been deferred will be paid promptly in the new fiscal year. Moreover, interest expenses incurred by hospitals as the result of borrowing to meet cash flow requirements during the reimbursement delay period will be includable in the hospitals' allowable costs and payable under the normal reimbursement rules. The normal PIP procedure would be fully restored in fiscal year 1985.

This provision would be technically effective upon enactment but will have an impact only during September 1983 and 1984.

Subtitle C—Miscellaneous Changes

Section 121: Audit and medical claims review

Present Law

Under current law and regulations, medicare contracts with intermediaries and carriers to perform a variety of day-to-day administrative and operational tasks for the program, including the review of claims and the conduct of audits.

Explanation of Provision

The amendment requires that the medicare contractor budgets for fiscal year 1983, 1984 and 1985 be supplemented by $45 million in each year to be spent specifically for contractor audit and medical review activities.

The fiscal year 1983 budget request for medicare contracting is insufficient to assure adequate medical review and audit by intermediaries and carriers. As a result, the program stands to make excessive benefit payments through a failure to identify improper billings and detect reported costs that are not reimbursable. It is believed that adequate funding of medical review and audit activities is necessary if cost-effective program management is to be achieved. It is intended that these funds not supplant funds that would otherwise be appropriated for these purposes, but rather that they supplement these amounts.

The provision would be effective for the 3 consecutive fiscal years beginning on October 1, 1982.

Section 122: Extending medicare proficiency examination

Present Law

Current law authorizes the Secretary of HHS to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet formal educational requirements. The existing authority expired December 31, 1980.

Explanation of Provision

The bill extends to September 30, 1983, the authority of the Secretary to conduct such proficiency examinations. It is believed that proficiency examinations represent an effective mechanism for identifying competent health personnel who may lack the necessary credentials otherwise required under personnel standards contained in medicare's conditions of participation

The provision is effective upon enactment.

Section 123: Prohibiting retroactivity of regulations regarding access to books and records

Present Law

Section 952 of P.L. 96-499, The Omnibus Budget Reconciliation Act of 1980, provides that medicare will not reimburse amounts paid by providers under contracts for services between the provider

and any of its subcontractors, whose value or cost over a twelve month period is $10,000 or more and which are entered into after enactment of the bill (December 5, 1980), unless such contracts contain a clause providing that the subcontractor shall make available to the Secretary of Health and Human Services and the Comptroller General, upon request, the contract, and the books, documents and records of the subcontractor that are necessary to verify the nature and extent of the costs incurred by the provider for a service covered by the specified subcontract. Books, papers and records covered by this provision must be preserved for four years after the furnishing of services pursuant to the contract.

The provision, enacted in 1980, although effective upon enactment, requires the Secretary to prescribe in regulations the procedures and criteria to be used in obtaining access to the appropriate books, documents and records. The regulations have yet to be proposed.

Explanation of Provision

The bill changes the effective date of section 952 so that it would apply only to books, documents, and records relating to services furnished on or after the date on which final regulations are first published.

It is still believed that the requirement for access to the books and records of medicare subcontractors is necessary both to strengthen the Secretary's capacity to preclude or detect fraud and abuse and to conform medicare practice to the prevailing practice of other Federal agencies which buy services in the private sector. It is urged, therefore, that the Secretary promptly issue the necessary regulations.

Administration's regulatory actions

Present Law

The Administration has indicated its intention to make certain changes in medicare payment and to take certain other actions which would result in reduced expenditures for the medicare program.

Explanation of Provision

The committee anticipated the prompt accomplishment of the Administration's planned regulatory actions and voted to give recognition to them and to the savings they are estimated to achieve. These actions were assumed by the conference report accompanying S. Con. Res. 92 in arriving at the reconciliation instruction to the Committee on Ways and Means. The actions include implementing a Health Care Financing Administration and private sector utilization review initiative; tightening reimbursement for hospital-based physicians; eliminating duplicate payments for overhead with respect to physicians who provide outpatient services; eliminating duplicate payment for private rooms; and establishing a single reimbursement limit for hospital-based and free-standing skilled nursing facilities and a single rate for hospital-based and free-standing home health agencies.

TITLE II. UNEMPLOYMENT COMPENSATION PROVISIONS

Subtitle A—Federal Supplemental Unemployment Compensation Program (Sections 201-206)

Present Law

State Unemployment Compensation Benefits

States provide State financed unemployment compensation benefits to unemployed individuals who meet the qualifying requirements of State law.

In all States, in order to receive State benefits, an individual must have earned a specified amount of wages and/or worked for a certain period of time prior to filing for unemployment compensation. There is, however, substantial variation among the States in the amount of previous earnings or employment necessary to qualify for benefits. In addition, all States require that, to qualify for benefits, the claimant must have been "involuntarily" unemployed; must be able to work, available for work, and seeking work; and must not refuse an offer of suitable employment.

Most States provide up to a maximum of 26 weeks of State unemployment compensation benefits to unemployed individuals who meet the qualifying requirements of State law. Many claimants qualify for less than the maximum 26 weeks, and in nine (9) States claimants may receive more than 26 weeks of State benefits. The number of weeks a claimant may draw benefits (except in the 11 "uniform duration" States) and the amount of his or her weekly unemployment payment varies with the level of wages or length of employment prior to the filing for benefits.

Federal-State Extended Unemployment Compensation Benefits

Under the permanent Federal-State extended unemployment compensation benefits program, additional weeks of unemployment compensation are payable to individuals who exhaust their State benefits during periods of high unemployment. Extended benefits are financed 50 percent from State trust funds and 50 percent from Federal unemployment insurance trust funds.

Under the extended benefits program, an individual may receive additional weeks of benefits equal to one-half of the number of weeks of State benefits to which he or she was entitled. No one, however, may receive more than 13 weeks of extended benefits, or a combined total of more than 39 weeks of State plus extended benefits.

Until September 25, 1982, extended benefits are payable in a State when, over the most recent 13-week period, the State insured unemployment rate (IUR—the percentage of workers covered by the State unemployment compensation program who are claiming State benefits) averages at least 4 percent and, in addition, is at least 20 percent higher than the State IUR during the comparable period in the two prior years. When the "20 percent" factor is not met, a State, at its option, may provide extended benefits when the State IUR reaches 5 percent. Forty (40) States have incorporated the optional 5 percent "trigger" into their State law. (See table 1:

Extended Benefits Trigger Notice No. 82-28.

TABLE 1.—EXTENDED BENEFITS: TRIGGER NOTICE NO. 82-28—STATE EXTENDED BENEFIT INDICATORS UNDER PUBLIC LAW 94-566 AS OF JULY 10, 1982

		Extended benefit indicators		Status of extended benefit periods beginning date (B), ending date (E)
		13-week IUR	Percent of prior 2 years	
On	Alabama*	4.89	118	E 7-31-82.
On	Alaska	6.66	96	B 1-19-75.
On	Arizona*	4.00	165	B 7-25-82.
	Arkansas*	5.03	114	E 7-3-82.
On	California	4.90	134	B 2-7-82.
	Colorado	2.83	140	E 1-24-81.
	Connecticut	3.25	131	E 1-24-81.
	Delaware*	2.93	100	E 7-17-82.
	District of Columbia	3.55	117	E 1-24-81.
	Florida	2.37	142	E 1-24-81.
	Georgia	3.19	132	E 1-24-81.
	Hawaii	3.31	122	E 1-24-81
On	Idaho	6.65	139	B 10-18-81.
On	Illinios	5.00	116	B 3-7-82.
	Indiana	4.29	115	E 7-17-82.
On	Iowa*	4.19	144	B 2-14-82.
	Kansas	3.93	161	E 1-24-81.
On	Kentucky*	5.42	112	B 6-6-82.
On	Louisiana	4.19	148	B 6-27-82.
	Maine	4.31	107	E 7-3-82.
On	Maryland	3.96	140	E 7-31-82.
	Massachusetts	3.55	117	E 6-26-82.
On	Michigan	[1](6.65)	(93)	B 2-28-82.
	Minnesota	3.76	136	E 7-10-82.
On	Mississippi	5.41	139	B 1-17-82.
	Missouri	3.82	98	E 6-19-82.
On	Montana*	5.03	128	B 4-11-82.
	Nebraska	2.60	151	E 1-24-81.
On	Nevada*	4.26	145	B 2-7-82.
	New Hampshire*	2.75	127	E 1-24-81.
	New Jersey	4.50	105	E 6-19-82.
	New Mexico	3.81	140	E 1-24-81.
	New York	3.60	104	E 1-24-81.
On	North Carolina	4.35	159	B 1-31-82.
	North Dakota*	2.93	120	E 1-24-81.
On	Ohio	5.45	123	B 1-17-82.
	Oklahoma	2.49	164	E 1-24-81.
On	Oregon	6.85	120	B 3-16-80.
On	Pennsylvania	6.21	132	B 1-24-82.
On	Pureto Rico	8.54	117	B 2-23-75.
On	Rhode Island	5.74	122	B 1-24-82.
On	South Carolina	5.32	157	B 1-10-82.
	South Dakota*	[1](2.10)	(118)	E 1-24-81.
On	Tennessee	4.96	130	B 1-24-82.
	Texas	1.71	141	E 1-24-81.
On	Utah*	4.41	152	B 2-28-82.
On	Vermont	5.10	125	B 2-28-82.
	Virginia	2.21	122	E 1-24-81.
On	Virgin Islands	4.64	127	B 2-21-82.
On	Washington	6.31	138	B 7-6-80.
On	West Virginia	6.26	102	B 4-18-82.
On	Wisconsin	5.59	118	B 1-3-82.
	Wyoming*	3.35	236	E 1-24-81.

*State does not have 5 percent option in its law.
[1] Trigger indicator as of July 3, 1982.

Source: U.S. Department of Labor, ETA, UIS, Division of Actuarial Services, July 26, 1982.

On September 25, 1982, as required by Section 2403 of the Omnibus Budget Reconciliation Act of 1981, both the State extended benefit triggers will be increased by 1 percentage point. In other words, after this date, extended benefits will be payable in a State when the State IUR equals 5 percent (rather than 4 percent) and is 20 percent higher than what it was during the comparable period in the previous two years; or, at State option, when the IUR equals 6 percent (rather than 5 percent), regardless of the State IUR in previous years.

Explanation of Provision

In States with high unemployment, jobless workers who exhaust their State unemployment compensation benefits and Federal-State extended unemployment compensation benefits would be provided additional weeks of benefits (Federal Supplemental Benefits—FSB) equal to one-half of the number of weeks of State unemployment benefits received by each claimant. No one, however, could receive more than 13 weeks of FSB or a combined total of more than 52 weeks of State benefits plus extended benefits plus the FSB provided by this bill.

FSB would be payable in States with unemployment high enough to trigger on the extended benefits program, as described above. In other words, FSB would be payable only in States where extended benefits are payable.

There would be no additional eligibility requirements for receipt of FSB. An individual who has exhausted his or her State and extended benefits, whose benefit year ended on or after January 1, 1981, and who continues to meet all requirements for receipt of State and extended benefits, would be eligible to receive FSB, if the extended benefit program is triggered on in the State.

FSB provided under this bill, plus administrative costs of the program, would be financed from Federal general revenues. The program would be in effect from the date of enactment until September 30, 1983.

Current economic conditions make it necessary to provide additional weeks of unemployment compensation for those unemployed workers who are unable to find jobs. According to the most recent unemployment statistics, there are currently 10.4 million jobless workers. The current unemployment rate is 9.5 percent, the highest it has been since 1941. In addition, the number of unemployed workers who are exhausting their unemployment benefits is increasing rapidly. As of May, over 300,000 workers were exhausting their State unemployment benefits each month. Over 130,000 jobless workers exhausted their extended benefits in May, compared to 36,000 who exhausted extended benefits in March. (See Table 2: Unemployment Compensation (UC) Exhaustion Data). Because an increasing number of jobless workers are competing for a decreasing number of jobs, every month more and more individuals are exhausting their unemployment benefits before finding work.

This bill recognizes that, under these economic conditions, the current unemployment compensation program is inadequate, and that additonal weeks of unemployment benefits must be provided. The bill is limited in scope and designed to address the current eco-

nomic emergency thousands of families are facing. It is not a substitute for measures that will create new jobs and provide the necessary employment services that will insure full employment for American workers.

TABLE 2.—UNEMPLOYMENT COMPENSATION (UC) EXHAUSTION DATA

[In thousands]

A. U.S. TOTALS—NUMBER OF UC BENEFICIARIES WHO HAVE EXHAUSTED THEIR BENEFIT RIGHTS

	1979			1980			1981			1982	
	Reg.	EB		Reg.	EB		Reg.	EB		Reg.	EB
January	184	11	January	217	24	January	309	187	January	258	8.5
February	166	10	February	202	15	February	176	128	February	266	13.7
March	184	13	March	220	17	March	290	133	March	335	36.0
April	184	15	April	259	28	April	289	117	April	361	118.0
May	182	31	May	242	74	May	240	95	May	338	134.0
June	170	19	June	242	66	June	244	90			
July	150	13	July	298	67	July	247	48			
August	164	12	August	258	64	August	205	21			
September	140	11	September	259	139	September	207	22			
October	161	14	October	291	183	October	200	15			
November	161	12	November	259	146	November	203	14			
December	162	11	December	321	189	December	265	11			

B. PERCENT OF UC BENEFICIARIES WHO HAVE EXHAUSTED THEIR BENEFIT RIGHTS

1979		1980		1981		1982	
January	26.3	January	27.0	January	32.6	January	32.9
February	25.8	February	27.3	February	33.2	February	33.3
March	25.8	March	27.6	March	33.4	March	33.9
April	25.7	April	28.2	April	33.4	April	34.5
May	25.9	May	28.6	May	33.6	May	34.8
June	25.8	June	29.5	June	33.3		
July	25.7	July	30.3	July	32.9		
August	26.1	August	30.1	August	32.7		
September	26.3	September	32.3	September	32.2		
October	26.5	October	33.1	October	31.7		
November	26.6	November	32.8	November	32.1		
December	26.8	December	33.2	December	32.4		

The bill simply recognizes that, because of the large number of people looking for work, it is going to take many of them longer to find jobs.

The FSB program in this bill will provide a means for maintaining purchasing power for the long-term unemployed. In order to make the program as responsive as possible to our current economic conditions, the bill provides for a plan that can be implemented immediately upon enactment without the usual delays inherent in enacting an entirely new program. This is possible because the new FSB program established by this bill is modeled after the permanent extended benefits program and the FSB program that was in effect during the recessionary years of 1975–1977. Instructions and procedures should be modeled after those utilized regulations for

the previous FSB program and should be issued by the Secretary of Labor immediately following enactment of this bill.

The FSB program in this bill differs from current State programs and the extended benefits program with regard to financing. Under present law, State benefits are financed out of State unemployment trust fund revenues, and benefits provided under the extended benefits program are financed fifty (50) percent from State trust funds and fifty (50) percent from Federal unemployment trust funds. The third tier of benefits provided in this bill, and any administrative cost resulting from these additional weeks of benefits, would be financed solely from Federal general revenues. This decision is in keeping with the financing method chosen by the Congress for FSB benefits paid under the previous program after April 1, 1977.

Subtitle B—Taxation of Unemployment Compensation (Section 211)

Present Law

Under present law, all or a portion of unemployment compensation benefits paid pursuant to government programs may be included in the recipient's gross income. The amount of unemployment compensation that is included in adjusted gross income generally is limited to one-half of the excess of (1) the sum of the taxpayer's adjusted gross income, all unemployment compensation paid pursuant to government programs, all disability income of the type eligible for exclusion from income (under Code sec. 105(d)), and the amount allowed under the deduction for two-earner married couples over (2) the taxpayer's base amount.

The base amount is $25,000 in the case of a married individual filing a joint return; zero in the case of a married individual filing a separate return (unless he or she lived apart from his or her spouse for the entire taxable year); and $20,000 in the case of all other individuals.

An individual may be subject to an estimated tax penalty to the extent that estimated tax payments and withholding for a taxable year are less than 80 percent of actual tax liability for that year.

Reasons for Change

Even though the increases in outlays for unemployment compensation and AFDC attributable to Titles I and II of the bill are necessary, the current budget situation requires that where possible the budget deficit should not be increased. Thus, in order to increase fiscal year 1983 revenues by an amount approximately equal to the increased outlays for that year, the bill lowers the income thresholds which determine the amount of unemployment compensation includible in adjusted gross income. By extending the duration of unemployment benefits for those who cannot find work, while simultaneously increasing the taxation of benefits for those who have substantial amounts of other income during the year, the bill improves the targeting of available resources to those who are most in need.

Explanation of Provision

The bill reduces the base amounts for purposes of computing the amount of unemployment compensation included in adjusted gross income from $20,000 to $12,000 for single taxpayers and from $25,000 to $18,000 for married taxpayers filing joint returns.

Effective Date

General rule.—The provision will apply to payments of unemployment compensation made after December 31, 1981, in taxable years ending after that date.

Special rule for underpayment of estimated tax.—An individual will not be penalized for an underpayment of estimated tax to the extent that the underpayment is attributable to the inclusion in income of unemployment compensation received during 1982 that, but for the amendment lowering the base amounts, would not have been includible in income.

Special rule for fiscal year taxpayers.—A fiscal year taxpayer whose taxable year includes January 1, 1982 will take into account the entire amount of unemployment compensation received during the fiscal year for purposes of determining how much to include in income. However, the increase in adjusted gross income for that fiscal year which can occur as a result of this title of the bill will be limited to the amount of unemployment compensation paid after December 31, 1981.

Revenue Effect

The provision will increase fiscal year receipts by $696 million in 1983, $686 million in 1984, $611 million in 1985, $618 million in 1986, and $650 million in 1987.

Subtitle C—Financing Provisions (Sections 221-225)

Present Law

The Federal-State Unemployment Compensation (UC) system provides benefits to unemployed individuals who meet the qualifying requirements of State law. The Federal and State governments finance the system with separate payroll taxes on employers. Administrative funds are derived from the Federal payroll tax and benefits are paid mainly from State payroll taxes.

Federal unemployment taxes

Under the Federal Unemployment Tax Act (FUTA), a payroll tax of 3.4 percent on the first $6,000 of wages is levied on employers who, in the current or last year, employed at least one person for 20 weeks or had a quarterly payroll of at least $1,500. The FUTA tax is also levied on agricultural employers who employ 10 or more workers for 20 weeks or who have quarterly payrolls of $20,000 or more, and on employers who pay at least $1,000 a quarter for services performed by household workers.

If a State's unemployment compensation program meets the requirements of Federal law, as set forth in section 3304 of the Internal Revenue Code, employers in that State receive a 2.7 percent

credit against the 3.4 percent Federal unemployment tax. Thus, under present law, the standard *net* Federal tax rate in all States is 0.7 percent. (The Federal tax rate is higher in certain States that have outstanding unemployment insurance loans from the Federal Government.)

FUTA revenue flows into three Federal accounts in the Unemployment Trust Fund: (1) the Employment Security Administration Account (ESAA), (2) the Extended Unemployment Compensation Account (EUCA), and (3) the Federal Unemployment Account (FUA). ESAA finances administrative costs associated with Federal and State unemployment compensation and State employment service programs. EUCA finances the 50 percent Federal share of the Federal-State extended benefits program (EB), which provides up to an additional 13 weeks of benefits in States with high unemployment. FUA finances Federal loans to insolvent State unemployment compensation systems.

Title IX of the Social Security Act of 1935 prescribes the flow of FUTA revenue into and among these accounts. Under current law, the allocation of the 0.7 percent net FUTA is as follows:

(1) 65 percent of the revenue raised by the 0.7 percent FUTA tax (or 0.45 percentage points) goes to ESSA where most of it, up to 95 percent, may be appropriated for State administrative grants and the remaining 5 percent is available to meet Federal administrative costs;

(2) The remaining 35 percent of the 0.7 percent FUTA tax revenue (or 0.25 percentage points) flows into EUCA where it is used to finance the federal share of the EB program;

(3) When ESAA and EUCA statutory ceilings have been reached, any excess FUTA revenues flow into FUA for use in granting loans to States.

Under present law, the 0.7 percent net FUTA includes a temporary surtax of 0.2 percent which was levied beginning in 1977 to generate funds to repay advances from the Federal General Fund to EUCA to meet the costs of the EB program. These outstanding advances currently total over $7.5 billion. When these advances have been repaid, the 0.2 percent temporary tax will no longer be levied, and the net tax will drop to 0.5 percent. When this occurs, the allocation to EUCA will drop to 10 percent of the FUTA (or 0.05 percent).

State unemployment taxes

States also levy unemployment compensation taxes on all covered employers in the State. State taxes finance regular State benefits and one-half the costs of extended benefits. State unemployment funds are deposited with the Federal Government in the Unemployment Trust Fund which is part of the unified Federal budget. Each State has its own account into which its tax collections are deposited and from which benefit payments are withdrawn.

The Federal Unemployment Tax Act requires State laws to meet certain requirements regarding coverage, taxation, eligibility, and administration. The following requirements relate to State UC taxes: (1) all State UC tax revenue must be deposited in the respective State accounts in the Federal Unemployment Trust Fund; (2)

all money withdrawn from State accounts must be used only to pay benefits (or to refund erroneous tax contributions); and (3) the standard State tax rate levied on employers (currently 2.7 percent) may be lower than 90 percent of the gross FUTA rate only on the basis of the particular employer's recent experience with unemployment.

Within these requirements the method and level of taxation varies considerably among the States. Most States have a number of tax rate schedules and will use higher or lower schedules depending on the solvency of the States' trust fund. All jurisdictions, with the exception of Puerto Rico and the Virgin Islands, provide a system of experience rating under which State tax rates vary among employers according to the total amount of unemployment benefits that have recently been paid to former employees of each employer.

In 1981, the estimated average State tax rate was 2.4 percent of taxable wages, ranging from 0.5 percent in Texas to 4.0 percent in Michigan. All States have a wage base of at least $6,000. Twenty-five State programs have a higher wage base, ranging from $6,600 to $14,600.

In the case of nonprofit organizations and government entities, Federal law requires the State to provide the employer the option of reimbursing the fund for the actual cost of benefits to unemployed workers rather than being taxed.

Federal unemployment loans to States

A State that has depleted its own unemployment funds may receive Federal loans as necessary to pay regular State benefits. States that borrow funds have two to three years to repay the loan, depending on the month the loan is received. (Technically, a State has until November 10 of the calendar year in which the second consecutive January 1 passes with the State still having an outstanding advance. This means that a State may have from 22 months and 10 days to 34 months and 10 days to repay the advance, depending on when it obtained the outstanding loan.) If a State does not fully repay all loans within the two to three year period, employers in the State become subject to an annual reduction in the 2.7 percent credit against the 3.4 percent FUTA tax of 0.3 percent. In other words, the 0.7 percent net Federal unemployment tax rate becomes subject to annual increases, up to a maximum of 3.4 percent, until sufficient revenue has been raised to repay the State's entire outstanding loan balance. The annual reductions can be more than 0.3 percent in the fourth and fifth years a State has an outstanding loan balance if the average State tax rate is less than (a) 2.7 percent or (b) the average of the last 5 years benefit expenditures divided by taxable wages.

Provisions in the Omnibus Budget Reconciliation Act of 1981 modified FUTA provisions regarding Federal unemployment loans to the States. Effective April 1, 1982 through December 31, 1987, States will be charged interest on new loans that are not repaid by the end of the fiscal year in which they are obtained. Under previous law, States could receive these loans interest-free. The interest rate will be the same rate as that paid by the Federal Government on State reserves in the Federal Unemployment Trust Fund for the quarter ending December 31 of the preceding year, but not higher

than 10 percent per annum. States may not pay the interest directly or indirectly from State Unemployment Trust Funds.

Effective for taxable years beginning January 1, 1981, and ending December 31, 1987, in States that meet certain solvency requirements, the 0.3 percent per year increase in the net FUTA tax resulting from overdue Federal loans would be limited to the higher of: (a) the total of any such increases in effect in the year prior to the year the State meets the solvency requirements; or (b) 0.6 percent. There are four solvency requirements. The first two requirements apply for taxable years 1981 through 1987; the last two requirements apply for taxable years 1983 through 1987. A State qualifies for the limitation if the Secretary of Labor determines by November 10 of the tax year in question that:

(1) the State has not reduced its State unemployment taxes;

(2) the State has taken no action that results in a decrease in the solvency of the State unemployment trust fund (e.g., if it increases benefits it must provide for a commensurate increase in State unemployment taxes);

(3) the average unemployment tax rate (taxes divided by total wages) in the State equals or exceeds the average unemployment benefit-cost rate (i.e., benefits divided by total wages for the past five years); and

(4) the State's outstanding loan balance on September 30 of the tax year in question is not greater than its outstanding loan balance on the second preceding September 30 for tax year 1983, and the third preceding September 30 for subsequent years.

Explanation of Provision

Section 221 increases the Federal unemployment tax (FUTA) wage base from $6,000 to $7,000, effective January 1, 1983. This will also require States, in order for employers in the State to qualify for the 90 percent credit against the gross Federal tax rate, to have a State unemployment tax wage base of at least $7,000. The gross Federal unemployment tax rate will increase from 3.4 to 3.5, effective January 1, 1983. Employers in States with approved State unemployment programs will continue to receive the 2.7 offset credit, so the net Federal tax will be 0.8 percent (3.5 minus 2.7).

Effective January 1, 1985, the gross Federal tax rate will increase to 6.2 percent. This includes a permanent tax of 6.0 percent plus a temporary 0.2 percent that will remain in effect until all outstanding general revenue loans to the extended benefit (EUCA) account have been repaid. The offset credit will increase to 5.4 (90 percent of the permanent 6.0 tax rate). This means the net Federal tax rate will remain at 0.8 percent, paid on the first $7,000 in wages, until the EUCA account has paid off all general revenue loans, when it will drop to 0.6 percent.

Raising the permanent gross Federal tax rate to 6.0 percent and applying a 90 percent offset credit increases the State "standard tax rate" from 2.7 to 5.4 (5.4 is 90 percent of 6.0). The State "standard tax rate" is the basic rate from which variations in employer's State unemployment tax rates are computed according to each State's experience rating formula. No employer in a State can pay

a State tax below the standard rate unless his rate is reduced on the basis of the employer's previous unemployment experience, as measured by the State's experience rating system.

In other words, the effect of raising the permanent gross Federal tax rate to 6.0 percent is to increase the maximum State unemployment tax rate that States must have—in order for employers in the State to qualify for the 90 percent reduction in the Federal gross tax rate—from the current 2.7 percent to 5.4 percent. A State experience rating schedule will have to have potential tax rates ranging up to at least 5.4 percent. Because there is no minimum tax requirement, a State's experience rated schedule could result in employers in the State having tax rates that range from zero to at least 5.4 percent. If a State does not have an experience rated tax schedule and, therefore, imposes the same tax rate of all employers, under this provision that rate will have to be at least 5.4 percent. This bill does not change the present law provision which permits states to tax new employers at a rate as low as 1.0 percent until they qualify for a different tax based on their experience.

Table 3 summarizes the impact of Federal wage base and tax rate changes on State unemployment tax provisions. The wage base increase scheduled for January 1, 1983 will have no effect upon state taxes in the twenty-one states that already tax on a $7,000 base or higher shown in column (1) of the table. The states shown in column (2) must move up to a $7,000 base from the current figure shown. This will happen automatically under existing state legislation in the twenty-six states shown in column (2). Six states, indicated in column (3), have wage bases under $7,000 but no statute automatically adjusting to the federal base. These states will have to enact conforming legislation.

Column 4 indicates maximum tax rates in states with current maximums at, or above, 5.4 percent. Assuming those maximums are not reduced, they satisfy the "standard rate" that would be required by January 1, 1985. The 32 states with current maximums under 5.4 percent shown in column (5) would have to legislate a new range of rates with a maximum of at least 5.4 percent by January 1, 1985.

The provision would also modify the allocation of FUTA revenue among accounts in the Federal Unemployment Trust Fund. Sixty percent of the 0.8 percent FUTA (or 0.48 percentage points) would be allocated to the Employment Security Administration Account (ESAA) and 40 percent (or 0.32 percentage points) to the Extended Unemployment Compensation Account (EUCA). Upon repayment of Federal advances to EUCA, the elimination of the 0.2 percent temporary tax will reduce the net FUTA to 0.6 percent. At this time, the allocation to EUCA will be reduced to 20 percent of the 0.6 percent (or .12 percentage points).

Section 222 permits a State to make Federal unemployment loan repayments from its State trust fund account in lieu of further FUTA credit reductions, provided it meets several requirements. First, a State account must have sufficient funds, or suffficient income to enable it to repay an amount equal to at least the sum that the FUTA credit reduction would have generated plus any advances made to the State during the year. Second, after making this repayment, the State must retain enough funds in its account

to pay all State benefits for the next six months. Finally, the State must have made a change in its laws after receiving the first advance which results in an increase in the solvency of its unemployment compensation system. It is the intent that this provision allow a State to put together a multi-year financing reform package, and that reveunes raised by such a package in subsequent years count toward the optional repayment in those years. Further, States which enacted implementing legislation in anticipation that a provision similar to this section of H.R. 6878 would be enacted when first proposed in the 96th Congress should also be allowed to qualify to make loan repayments out of State trust funds on the basis of this earlier enacted State legislation. This provision is effective for tax years beginning after December 31, 1982.

Section 223 drops the additional credit reduction based on the State's previous 5-year benefit cost rate that applies in the fifth year a State has outstanding Federal unemployment loans. This amendment applies to a debtor State in any tax year beginning after December 31, 1982 in which the State has taken no action during the 12-month period ending on September 30 which has reduced the solvency of the State unemployment trust fund.

Section 224, beginning after December 31, 1982, provides that interest paid by States on Federal unemployment compensation loans will be credited to the Federal extended benefit (EUCA) account until all advances from general revenues to EUCA have been repaid.

Section 225 permits a State that is experiencing a continuous period of high unemployment to postpone interest payments on loans. In any year when a State's insured unemployment rate for the six month period ending December 31 of the immediately preceding taxable year equaled or exceeded 6.5 percent, the State could opt to pay the amount of interest due during such calendar year in four annual 25 percent installments. In other words, the State would be able to reduce payments of interest on Federal unemployment loans to twenty-five (25) percent of the amount due in any year, and thereby extend the payment of the total interest obigation over a four (4) year period, Interest would accrue on any interest payments so deferred. For any year in which the 6.5 percent IUR criterion was not met, the State would be required to pay the full amount of interest due that year plus any deferred interest due that year.

TABLE 3.—SUMMARY OF STATE UNEMPLOYMENT TAX PROVISIONS AS OF JANUARY 1, 1982

State	Taxable wage base			Maximum tax rate	
		Under $7,000 and:			
	$7,000 or higher	Provision to match FUTA base	No provision to match FUTA base	5.4 percent or higher	Under 5.4 percent
Alabama		$6,600			4.0
Alaska	$14,600				4.86
Arizona		6,000			2.9
Arkansas		6,900		6.1	
California		6,000			4.2
Colorado		6,000			4.5
Connecticut	7,000			6.0	

TABLE 3.—SUMMARY OF STATE UNEMPLOYMENT TAX PROVISIONS AS OF JANUARY 1, 1982—Continued

State	Taxable wage base			Maximum tax rate	
		Under $7,000 and:			
	$7,000 or higher	Provision to match FUTA base	No provision to match FUTA base	5.4 percent or higher	Under 5.4 percent
Delaware			$6,600	8.5	
District of Columbia	7,500			5.4	
Florida		6,000			4.5
Georgia		6,000			5.38
Hawaii	13,100				4.5
Idaho	13,200				4.0
Illinois	7,000			5.7	
Indiana		6,000			3.3
Iowa	8,700			6.0	
Kansas		$6,000			4.3
Kentucky	$8,000			10.0	
Louisiana		6,000			3.39
Maine		6,000			5.0
Maryland		6,000			5.0
Massachusetts		6,000		6.7	
Michigan		6,000		9.0	
Minnesota	8,300			7.5	
Mississippi		6,000			4.0
Missouri		6,600			5.2
Montana	8,000				4.4
Nebraska		6,000			3.7
Nevada	9,300				3.6
New Hampshire			$6,000	6.5	
New Jersey	8,200			6.2	
New Mexico	8,500				5.1
New York			6,000		5.2
North Carolina		6,000		5.7	
North Dakota	9,240				5.0
Ohio		6,000			4.8
Oklahoma		6,000			3.1
Oregon	11,000				3.8
Pennsylvania			6,600	6.6	
Puerto Rico	(1)				2.95
Rhode Island	8,600			6.0	
South Carolina		6,000			4.1
South Dakota		6,000		7.7	
Tennessee		6,000		7.0	
Texas			6,000		4.0
Utah	12,000				2.8
Vermont		6,000		6.0	
Virgin Islands	8,000				3.7
Virginia			6,000	6.9	
Washington	10.800			9.5	3.0
West Virginia	8,000			9.5	
Wisconsin		6,000		7.4	
Wyoming		6,000			3.08

[1] Total wages.

The financing provisions contained in sections 221–225 are intended to accomplish three basic objectives: to generate revenue needed by a severely underfinanced Federal-State unemployment insurance system; to enhance state experience-rated unemployment tax structures; and to provide modest relief to states most severely impacted by current high unemployment rates.

Financing

The Federal-State unemployment insurance system is in serious financial difficulty. Estimated FUTA receipts are inadequate to cover Federal UC and employment service obligations and State trust fund accounts are severely strained.

Since the 1974–1975 recessionary period, the Unemployment Trust Fund has borrowed substantial sums from the Federal General Revenue Fund. Estimates by the Department of Labor (DOL) project that total Trust Fund debt to the General Fund will rise from $13.1 billion at the end of fiscal year 1981 to $21.7 billion in fiscal year 1984, thereafter declining to $13.4 billion in fiscal year 1987.

A substantial portion of the UC Trust Fund debt stems from State borrowing and the generally poor financial condition of many State accounts. Prior to 1974, although annual benefit payments exceeded State tax contributions in some States, total net reserves in State accounts were believed sufficient to cover benefit expenditures. During the 1974–1975 recessionary period, however, State net reserves declined sharply as benefit expenditures doubled and State tax contributions declined.

Further, despite positive overall total net reserves in State accounts in the early 1970's, between 1975 and 1978, 25 State UC programs became insolvent. By the end of fiscal year 1979, 25 States had borrowed over $5.6 billion, compared with total State borrowing of $100 million by three States prior to 1975.

As of June 1982, 19 States owe $7.8 billion in outstanding unemployment loans. DOL predicts loans will increase during fiscal years 1982, 1983 and 1984, with additional net borrowing of $3.3 billion, $4.5 billion, and $2.2 billion respectively.

The adjustments in the FUTA tax and wage base will provide new Federal and State revenue to help assure adequate financing of unemployment compensation adminstrative and benefit costs. The increase in the wage base is projected to produce new Federal revenues of $2.1 billion during fiscal year 1983 through 1986. Over the same period, $2.2 billion in additional Federal revenue will be derived from the increase in the net FUTA tax rate. State revenue over the four-year period is estimated to increase $4 billion in States which must make wage base and maximum tax rate adjustments. The combined federal and state revenue increase, all of which is reflected in the federal unified budget, is expected to be $1.4 billion in fiscal year 1983, $2.4 billion in fiscal year 1984, $2.9 billion in fiscal year 1985 and $2.8 billion in fiscal year 1986.

Depending on their personnel patterns, employers are differently affected by FUTA rate and base increases. The provisions in section 221 reflect the position that increasing both the FUTA tax rate and wage base is more equitable than concentrating the entire increase on either the rate or base alone.

The shift in the allocation of revenues between the ESAA (administration) and EUCA (EB) accounts is intended to target a greater portion of the new revenues generated under Section 221 to EUCA than would be the case under present law. This reflects both a desire to repay the EUCA account as promptly as possible so that the 0.2 percent additional tax imposed in 1977 can be eliminated

and the fact that allocating 60 percent of the total FUTA revenues to ESAA (instead of 65 percent as under present law) should provide enough funding to meet federal and state administrative expenses without resorting to borrowing from general revenues. Any excess ESAA funds remaining at the end of a year flow into EUCA. Although the allocation to EUCA drops from 40 to 20 percent of FUTA when the EUCA account is repaid, the net receipts flowing into EUCA will, because of the increased federal wage base and rate, still be greater than they would have been under present law. This allocation therefore, is expected to continue to generate funds sufficient to build adequate reserve in the EUCA account to cover future EB payments without resorting to Federal general revenues.

Because the need for additional FUTA revenues is immediate, the increase in the gross tax to 3.5 percent and the net tax to 0.8 percent is effective January 1, 1983 and continues for the next two years, until the restructured FUTA tax structure takes effect. This immediate increase can take place solely on the Federal level without necessitating accompanying adjustment of state laws and tax structures, which is normally a two-year process.

Provisions in sections 221, 222, and 224 of the bill are intended to move state unemployment taxes toward a fuller experience-rated system. First, the restructuring of the FUTA tax, effective beginning in 1985, is intended to extend the States' experience-rated tax schedules so that the proportion of taxes paid by employers will more nearly equal the cost of benefits paid to their former employees. Under state experience rating systems, employer's tax rates are based on some factor, such as benefits paid out, in relation to the employers' payrolls. Actual tax rates are assigned according to tax schedules under which employers with the worst experience in terms of these ratios, are assigned rates higher than those with better experience. Under the bill's provisions, the maximum tax charged by states to employers with the worst rating will be increased from 2.7 percent to at least 5.4 percent. In addition to distributing the burden of financing the system more heavily on the employers who use it the most, it is expected that the expanded experience rating will encourage employers to police claims against them more closely, since additional charges will result in increased payroll taxes.

The provisions permitting States to make Federal unemployment loan repayments from their experience-rated State trust fund accounts, in lieu of further flat-rated FUTA credit reductions, move state tax structures in the direction of more experience rating. Similarly, the crediting of interest payments made by states to the EUCA account, instead of to federal general revenues as under present law, will hasten the repayment of the EUCA account and the removal of the 0.2 percent additional tax imposed on all employers.

The deferral of interest and the suspension of the additional credit reduction in the fifth year a state has an outstanding debt, sections 222 and 225, are provisions aimed at providing fiscal relief to states and employers in those states most heavily impacted by high unemployment rates. In the fifth year of a state loan repayment schedule, in addition to the annual 0.3 percent federal credit reduction, present law requires a comparison of the debtor state's

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average tax rate to its average benefit cost rate for the previous five years. If the cost rate is higher, the difference between the two is added to the regularly scheduled FUTA credit reduction. For a state that has experienced inordinately high benefit costs due to protracted high unemployment, that extra credit reduction could mean a very sharp federal tax increase, perhaps to the full limit of the federal tax, 6.2 percent. This fifth year provision, which has never been imposed, was intended to encourage states to impose taxes at levels sufficient to meet their benefit costs. The possibility that states with relatively high tax rates would be affected by this provision because their benefits has been affected by a recessionary economy was not anticipated. Now that this appears to be a possibility in one or more states and because the gross FUTA tax is being almost doubled, it is appropriate to relieve states of the burden of this extra credit reduction, provided they have taken no action to reduce the solvency of their unemployment compensation systems.

Section 226: Treatment of certain employees of institutions of higher education

Present Law

Prior to 1970, there was no provision in Federal law explicitly requiring States to grant or deny unemployment compensation eligibility to employees of colleges or universities. The Employment Security Amendments of 1970 (P.L. 91--373) required States to extend unemployment insurance coverage to employees of State and other nonprofit colleges and universities. Present law specifically requires States to deny unemployment benefits to individuals employed by institutions of higher education in an instruction, research, or principal administrative capacity for any week commencing during the period between two successive academic years or terms if such employees worked during the first term and have a contract or reasonable assurance that they will be working for any educational institution in the second year or term.

Because non-teaching, non-research and non-administrative employees of colleges and universities were not specifically included in the special denial provisions, current law requires States to treat these workers on the same basis as, or according to the same qualification requirements that are applied to, all other workers in the State. In other words, a State cannot automatically deny unemployment compensation benefits to a college cafeteria worker or policeman during the summer break or other recess periods. Benefits can be denied to such a worker if he or she does not meet the other requirements of State law, which would include having sufficient wages prior to applying for benefits, being involuntarily terminated from the job, being able and available for seeking employment.

The Unemployment Compensation Amendments of 1976 (P.L. 94-566) required States to extend unemployment insurance protection to employees of elementary and secondary schools. These amendments also required that unemployment compensation benefits be denied, during periods between terms, to those elementary and secondary school employees who work in an instructional, research or principal administrative capacity. In addition, the 1976 amendments

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gave the States the option of extending the same between-term denial of benefits provisions to all other employees of elementary and secondary schools. The amendments, however, did not extend this optional between-term denial authority to non-teaching, non-research, and non-administrative employees of colleges and universities.

Explanation of Provision

Section 226 allows States to deny unemployment compensation benefits during periods between academic years or terms to those employees of institutions of higher education who are not already subject to the Federal between-term denial of benefits requirement. Under this section, States may deny benefits during school recess periods to these employees if there is reasonable assurance that the individual will be employed by the institution at the beginning of the forthcoming academic year or term, or at the end of the recess period, to perform the same services performed prior to the recess period.

Effective upon enactment for college and university employees, and effective January 1, 1984 in the case of elementary and secondary school employees, who are subject to the optional between-terms denial authority, the amendment stipulates that retroactive benefits must be paid to such non-teaching, non-research and non-principal administrative employees who were denied benefits during a recess period due to reasonable assurance of employment at the end of the period, but were subsequently not offered that employment. Such an individual could receive a retroactive payment of benefits for each week that he or she filed a timely claim (as required for the reporting requirements for regular benefits under state law) for benefits during the between term or recess period and was denied benefits solely because of the optional between-term denial of benefits authority provided in this amendment.

Retroactive benefits would be paid to an individual where the school does not make a good faith offer to employ the person in a non-teaching, non-research or non-principal administrative position following the recess period in question. Any attempt by a school to avoid the payment of retroactive benefits by purposely employing the person for a temporary period of time would not be a good faith offer and, therefore, would violate the intent of this amendment.

A total of 44 States have adopted the option of denying benefits during recess periods to non-instructional, non-research and non-administrative employees of elementary and secondary schools. The provisions in this section would allow states to extend these denial provisions to such employees of colleges and universities and, therefore, treat all such educational employees in a consistent manner.

Subtitle D—Short-Time Compensation (Sections 231-234)

Present Law

Under present law, most individuals who receive unemployment insurance payments are totally unemployed. However, all State

laws provide partial benefits for claimants who work less than regular full-time hours (as defined by each State law). Most State laws disregard small amounts of earnings from part-time employment but reduce benefits $1 for each additional dollar or earnings up to the State weekly benefit amount. Therefore, there is little incentive for workers to increase part-time work effort, if available, because the combined amount of unemployment benefits plus wage income is not increased by additional earnings. In many States, moreover, when the amount of part-time earnings exceeds the State weekly benefit amount (about one-half of full-time weekly wages), all unemployment compensation assistance terminates. (The national average weekly unemployment benefit is $108) Therefore, most State unemployment compensation laws do not allow partial unemployment benefits in a way that encourages "worksharing" because partial benefits generally end when a worker earns slightly more than one-half of full-time wages.

Explanation of Provision

Section 234 would direct the Department of Labor (DOL) to develop model worksharing legislation and to assist States who wish to establish short-time compensation programs.

Under short-time compensation programs, employees who have accepted a reduction in their work hours, in order to prevent layoffs within a specified firm, would be eligible for partial, prorated unemployment benefits. For example, workers reduced from 5 days a week to 3 days would receive an unemployment compensation payment of two-fifths the State's normal unemployment benefit for a full week of unemployment. In addition, the workers would receive wages for the days actually worked.

Short-time compensation or worksharing is a type of adjustment to recessionary conditions that has been used successfully in other nations. The objective of such programs is to avoid large-scale layoffs, help firms retain their trained workforce, and to reduce hiring and retraining costs.

Under the provision, State short-time compensation programs would be optional. The participation of employers and employees would be voluntary, and only upon joint agreement. DOL would be required to review programs developed by the State for compliance with all applicable Federal laws and to evaluate the operation and impact of programs.

Title III—Aid to Families With Dependent Children and Child Support Enforcement Programs

Section 301: Treatment of earnings

Present Law

Prior to Federal amendments enacted in the 1960's, if an AFDC parent took a job, the family's AFDC benefits were reduced dollar-for-dollar by the amount of any earnings. In other words, there was no net financial gain from working. Furthermore, any work-related expenses—such as transportation and child day care costs, and mandatory tax and other wage deductions—could result in the

family actually having less net or disposable income than if the parent did not work. In order to insure that taking a job would increase an AFDC family's disposable income, Federal amendments enacted in 1962 and 1967 required States to apply certain procedures (i.e., earnings disregards) in determining the monthly benefit level of an eligible AFDC family in which a member was employed. These amendments required that certain amounts of earnings not be counted against, or reduce the family's monthly AFDC benefit. That is, certain amounts of monthly earnings had to be disregarded in determining the AFDC payment so the family would have a higher amount of disposable income (wages minus work expenses plus AFDC benefits) because of the earnings; and, therefore, there would be a financial incentive for AFDC parents to seek employment.

Prior to enactment of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), in determining a working AFDC family's benefit level for a month, States were required to reduce the State monthly payment by the amount of the family's earnings that remained after the following amounts had been excluded or disregarded: (1) the first $30 of earnings; (2) plus one-third of remaining earnings; (3) plus work expenses for the month (any expenses, including child day care, reasonably attributable to the earning of income). (The $30 plus one-third disregards could be applied in determining the monthly benefit only if the family was determined to be eligible for AFDC without the application of these disregards, or received AFDC in any of the preceding four (4) months.)

Several amendments contained in the Budget Reconciliation Act of 1981 virtually eliminated the financial incentive for AFDC parents to seek employment or, for those with jobs, to continue working. These amendments limited the disregard for work expenses to a standard $75 per month for full-time employment and capped the child care disregard at $160 per month per child. The application of the $30 plus one-third disregard was limited to only 4 consecutive months. States were required to assume a person with earnings was receiving the earned income tax credit (EITC) on an advance monthly basis, and reduce the family's benefits accordingly, even if the person was not receiving a monthly EITC. And, States were prohibited from paying AFDC to any family with a gross income (i.e. income, including earnings, without the application of any earned income disregards) at or above 150 percent of the State's standard of need, which in many States nullifies the effect of earned income disregards.

Explanation of Provision

Section 301 amends the 1981 Reconciliation Act Amendments to the AFDC earned income disregards summarized above. It requires States to apply a modified set of earned income disregards that would restore to the AFDC program the financial work incentives that were eliminated by the 1981 Reconciliation Act amendments. Furthermore, it would make needed improvements in the disregard provisions that were in the law prior to the enactment of the Reconciliation Act by (1) increasing the $30 per month disregard to $50; (2) standardizing and limiting the work expense disregard at

20 percent of gross earnings (up to a maximum of $175 per month); (3) maintaining the $160 per child monthly ceiling on child care costs; and (4) maintaining the change in the order of the "one-third" disregard so that it applies only to earnings remaining after all other disregards have been applied.

Specifically, the provision would require States to disregard the following amount of earnings, in the following order:

(a) *Eligibility determination.* In place of itemized work expenses, (1) 20 percent of gross earnings (monthly wages, salary or net earnings from self employment), plus the full amount of any cost reasonably incurred in producing self-employment income, up to a maximum of $175; and (2) child care costs up to $160 per child. If a family with earnings is determined to be eligible for AFDC with the application of these two disregards, the following disregards are applied to determine the family's benefit level for the month:

(b) *Benefit calculation.*—(1) $50; (2) 20 percent of gross earnings (monthly wages, salary or net earnings from employment), plus the full amount of any costs incurred in producing self-employment income, up to $175 per month; (3) child care costs up to $160 per child per month; and (4) one-third of remaining earnings.

For two-parent AFDC families, the provision would allow States to limit the disregards to 20 percent of gross earnings (up to $175 per month) for eligibility determination; and $50 plus 20 percent of gross earnings (up to $175 per month) for benefit calculation.

In addition to requiring these disregards, Section 301 of the bill would repeal the provisions of the Reconciliation Act that limit to 4 months the application of certain disregards. In other words, there would be no time limitation on the application of the one-third or any of the other disregards. Also, as explained below, section 302 of the bill would repeal the Reconciliation Act provision that can nullify the effect of earned income disregards by limiting AFDC eligibility to families with gross incomes at or below 150 percent of the State standard of need.

Section 301 also assures that participation by an AFDC youth in a Comprehensive Employment and Training Act (CETA) youth program would not affect the family's AFDC eligibility or benefit amount. Under present law, youths who do not meet the AFDC definition of "student" may cause the family benefit to be reduced or terminated as the result of their participation in a CETA youth program. The provision would specifically require the States to disregard any income and allowances received by an AFDC youth as the result of participation in youth program under the title IV of CETA or under corresponding provisions of a successor statute. Title IV includes the Job Corps, summer youth, and other special programs for youth. The provision of the bill which repeals the 150 percent gross income limitation would further preclude the possibility that income derived from participation in a CETA youth program would affect the family's AFDC eligibility.

Section 301 would be effective October 1, 1982. A State, however, could implement the provisions at any point after enactment prior to October 1, 1982.

Changes enacted in the 1981 Budget Reconciliation Act have substantially eliminated the intended work incentive effect of the AFDC earned income disregards. Because of the 1981 Reconcili-

ation Act changes, it is now financially advantageous for many working AFDC mothers to stop working and become totally dependent on welfare; and it is financially disadvantageous for many of those on AFDC to seek employment or accept jobs that might become available to them.

In other words there are thousands of working AFDC mothers with children who have lost or could lose AFDC and Medicaid, or have experienced a substantial reduction in AFDC benefits, because of changes in the AFDC program mandated by the Omnibus Budget Reconciliation Act of 1981. These are women raising young children by themselves and working at the only jobs that are available to them, which are usually the lowest paying jobs in the country and which generally provide no health insurance protection.

Female headed families are the most poverty prone families in the country. Today more than half of the total number of poor families are maintained by women. They have a poverty rate six times that of male headed families. (The poverty rate for female headed families is 32 percent, as compared to 5 percent for male headed families.) Even in those female headed households with children under 18, where the mother is working, one-fourth had incomes below the poverty level in 1978.

According to the most recent available information, prior to the 1981 Reconciliation Act changes one-half of the working AFDC mothers nationwide made less than $400 a month, 70 percent earned less than $500, and 90 percent had monthly earnings under $700. Typically, these women were paid the minimum wage and worked as receptionists, waitresses, and hospital orderlies, nurse's aids or clerk-typists. Many of them worked part-time because they could not obtain necessary day-care for their young children. Two-thirds of these families had one or two children, and about one-half had a child under 7 years of age.

Because of the low wages they received, and the earned income disregards in prior law, they and their children were receiving small amounts of AFDC which made them eligible for Medicaid. Now, however, *because they are working,* and because of the changes in the AFDC program, many have lost eligibility for AFDC and the health insurance protection of Medicaid, or have had their AFDC benefits reduced substantially.

Tables 4 and 5 show the work disincentive effect of the changes mandated in the 1981 Reconciliation Act. Table 5 shows, for example, that under present law, a mother with two children in the State of Pennsylvania may receive a total of $475 a month in combined food stamps and AFDC benefits. If she goes to work at the minimum wage ($581 a month), and incurs child care costs of $125 per month, her net disposable income will not be increased at all. In fact, it will be reduced by $1. A mother in a similar situation in California will actually lose $58 a month. The Congressional Budget Office estimates that, because of the work disincentives created by the 1981 Reconciliation Act, working mothers in 100,000 to 125,000 AFDC families will leave their jobs and go completely on welfare.

Provisions contained in this bill reflect the following questions:

1. Is it reasonable to eliminate financial incentives to work and at the same time espouse a goal of eliminating the cycle of welfare dependency?

2. Should not Federal policy support working poor, female headed families who, with some public assistance, are in a better position to contribute to their family's income and work toward the possibility of higher earnings and a better living for their family?

These provisions also reflect information from some States that the AFDC changes made by the Reconciliation Act could result in increased AFDC costs. For example, information on the AFDC program in the State of Utah indicates that, for the three month period from December 1, 1981 to February 25, 1982, there was a significant decline in the number of working AFDC recipients and an increase in monthly program payments of $32,000. According to this information, a particularly sharp reduction occurred in the number of mothers with young children who were working. Between December 1 and February 25, the number of working AFDC recipients with children under age 6 declined by 40 percent.

The earned income disregards required by this section are based on the premise that there should be a financial incentive for those who are receiving aid to take advantage of the job opportunities available to them and to work to the full extent of their capabilities. The financial incentives to work provided under the bill are demonstrated in the last columns of Tables 4 and 5.

The AFDC disregards in this bill provide the greatest financial incentive for individuals in part-time and full-time entry-level, minimum wage jobs: those jobs that are most likely to be available to members of AFDC families. In addition, by capping the work expense disregard at the lower of 20 percent of gross earnings or $175 per month and applying the one-third work incentive disregard to net rather than gross earnings, these disregards correct the major problems with the disregards that were in effect prior to the 1981 Reconciliation Act. Compared with prior law, the disregards in this bill significantly lower the amount of earnings a family can have and still remain eligible for AFDC, while at the same time, they provide a substantial financial incentive for AFDC parents to take part-time and full-time minimum wage jobs.

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TABLE 4.—COMPARISON OF MONTHLY BENEFIT AND DISPOSABLE INCOME AMOUNTS FOR A FAMILY OF 3 INDIVIDUALS WITH NO EARNINGS AND WITH EARNINGS EQUAL TO $290 (HALF-TIME MINIMUM WAGE WORKER) UNDER PRIOR LAW, CURRENT LAW AND THE PROVISIONS IN H.R. 6878—NO CHILD CARE

	Need std.	No earnings		Earnings=$290 per month							
				Prior law		Current law (1st 4 mo)		Current law (after 4 mo)		H.R. 6369	
		AFDC	AFDC plus FS	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages
Alabama	384	118	301	0	434	0	432	0	432	0	432
Alaska	571	571	635	422	729	403	714	289	634	434	736
Arizona	233	202	377	53	471	34	456	0	432	65	748
Arkansas	234	140	323	0	434	0	432	0	432	0	432
California	506	506	590	357	684	338	669	224	589	369	690
Colorado	380	313	455	164	549	145	533	31	454	176	555
Connecticut	498	498	584	349	678	330	663	216	583	361	685
Delaware	266	266	422	117	516	98	501	0	432	129	522
District of Columbia	586	300	445	151	540	132	642	18	445	163	546
Florida	209	209	382	60	476	41	461	0	432	72	482
Georgia	366	183	364	34	456	15	442	0	432	46	464
Hawaii	468	468	563	319	657	300	612	186	562	331	664
Idaho	554	305	449	156	543	137	528	23	448	168	550
Illinois (Cook County)	486	302	447	153	541	134	526	20	446	165	548
Indiana	307	255	414	127	523	108	508	0	432	139	529
Iowa	360	360	488	211	582	192	566	78	487	223	588
Kansas	353	353	483	204	577	185	561	71	482	216	583
Kentucky	188	188	367	39	461	20	446	0	432	51	468
Louisiana	505	190	368	41	463	22	447	0	432	53	469
Maine	415	301	446	152	540	133	525	19	445	164	547
Maryland	373	270	425	121	519	102	503	0	432	133	525
Massachusetts	379	379	501	230	595	211	580	97	500	242	601
Michigan: Washtenaw County	462	423	532	274	626	255	610	141	531	286	633
Wayne County	432	395	512	246	606	227	591	113	511	258	612
Minnesota	446	446	548	297	642	278	627	164	547	309	648
Mississippi	220	220	390	71	484	52	468	0	432	83	490
Missouri	312	248	409	99	503	80	488	0	432	111	510
Montana	370	306	450	157	544	138	529	24	449	169	550
Nebraska	350	350	480	201	575	182	559	68	480	213	581

TABLE 4.—COMPARISON OF MONTHLY BENEFIT AND DISPOSABLE INCOME AMOUNTS FOR A FAMILY OF 3 INDIVIDUALS WITH NO EARNINGS AND WITH EARNINGS EQUAL TO $290 (HALF-TIME MINIMUM WAGE WORKER) UNDER PRIOR LAW, CURRENT LAW AND THE PROVISIONS IN H.R. 6878—NO CHILD CARE—Continued

	Need std.	No earnings		Earnings = $290 per month							
				Prior law		Current law (1st 4 mo)		Current law (after 4 mo)		H.R. 6369	
		AFDC	AFDC plus FS	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages
Nevada	285	271	425	122	519	103	504	0	432	134	526
New Hampshire	326	326	464	177	558	158	543	44	463	189	564
New Jersey	360	360	487	211	582	192	566	78	487	223	588
New Mexico	233	233	399	86	493	65	478	0	432	96	495
New York (Suffolk County)	507	507	590	358	685	339	669	225	590	370	691
(New York City)	424	424	532	275	626	256	611	142	531	287	633
North Carolina	384	192	370	43	464	24	449	0	432	55	471
North Dakota	357	357	486	208	680	189	564	75	484	220	586
Ohio	431	263	420	114	514	95	499	0	432	126	520
Oklahoma	282	282	433	133	527	114	512	0	432	145	534
Oregon	339	339	473	190	567	171	552	57	472	202	573
Pennsylvania	332	332	468	183	562	164	547	50	467	195	569
Rhode Island	453	453	553	304	647	285	632	171	552	316	653
South Carolina	187	187	366	38	461	19	445	0	432	50	467
South Dakota	321	321	460	172	554	153	539	39	459	184	561
Tennessee	179	122	305	0	434	0	432	0	432	0	432
Texas	168	118	301	0	434	0	432	0	432	0	432
Utah	536	367	492	218	587	199	571	85	491	230	593
Vermont	734	506	590	357	684	338	669	224	589	369	690
Virginia	344	310	452	161	547	142	531	28	452	173	553
Washington	670	451	551	302	645	283	630	169	550	314	652
West Virginia	275	206	380	57	474	38	459	0	432	69	480
Wisconsin	556	473	567	324	661	305	646	191	566	336	667
Wyoming	360	360	488	211	582	192	566	78	487	223	588
Guam	255	255	414	106	508	87	493	0	432	118	515
Puerto Rico	180	90	273	0	432	0	432	0	432	0	432
Virgin Islands	209	209	382	60	476	41	461	0	432	72	482

Note: The 2d and 3d columns reflect AFDC and AFDC plus food stamp amounts for families with no earnings. These amounts are the same under prior law, current law and the HR 6369. The columns labeled "AFDC plus FS plus Net Wages" are the sum of the AFDC, food stamp benefits, the assumed earnings of $290 per month, an earned income tax credit of $29 minus payroll taxes of $19 and transportation expenses of $25 per month. An excess food stamp shelter deduction of $90 per month is assumed.

TABLE 5.—COMPARISON OF MONTHLY BENEFIT AND DISPOSABLE INCOME AMOUNTS FOR A FAMILY OF 3 INDIVIDUALS WITH NO EARNINGS AND WITH EARNINGS EQUAL TO $581 (FULL-TIME MINIMUM WAGE WORKER) UNDER PRIOR LAW, CURRENT LAW AND THE PROVISIONS IN H.R. 6878 CHILD CARE EXPENSES OF $125 PER MONTH ARE ASSUMED

	No earnings		Earnings = $581 per month							
			Prior law		Current law (1st 4 mo)		Current law (after 4 mo)		H.R. 6369	
	AFDC	AFDC plus FS	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages	AFDC	AFDC plus FS plus net wages
Alabama	118	301	0	478	0	474	0	474	0	474
Alaska	571	643	413	767	316	695	158	585	361	727
Arizona	202	384	414	509	0	474	0	474	0	474
Arkansas	140	323	0	478	0	474	0	474	0	474
California	506	597	348	722	251	650	93	539	296	681
Colorado	313	462	155	584	58	515	0	474	103	546
Connecticut	498	592	340	716	243	644	85	536	288	676
Delaware	266	429	108	554	11	482	0	474	56	513
District of Columbia	300	453	142	577	45	506	0	474	90	537
Florida	209	389	51	514	0	474	0	474	0	474
Georgia	183	366	25	496	0	474	0	432	46	464
Hawaii	468	571	310	695	213	623	55	513	258	655
Idaho	305	457	147	581	50	509	0	474	95	540
Illinois (Cook County)	302	454	144	579	47	507	0	474	92	538
Indiana	255	422	118	561	0	474	0	474	66	520
Iowa	360	495	202	619	105	548	0	474	150	579
Kansas	353	490	195	614	98	543	0	474	143	574
Kentucky	188	371	30	499	0	474	0	474	22	489
Louisiana	190	373	32	500	0	474	0	474	0	474
Maine	301	454	143	578	46	506	0	474	91	538
Maryland	270	432	112	556	15	485	0	474	60	516
Massachusetts	379	508	221	633	124	561	0	474	169	592
Michigan:										
Washtenaw County	423	539	265	664	168	592	10	481	213	623
Wayne County	395	520	237	644	140	572	0	474	185	604
Minnesota	446	552	288	680	191	608	33	497	236	639
Mississippi	220	397	62	521	0	474	0	474	10	481
Missouri	248	416	90	541	0	474	0	474	38	501
Montana	306	457	148	582	51	510	0	474	96	541
Nebraska	350	488	192	612	95	540	0	474	140	572
Nevada	271	433	113	557	16	485	0	474	61	517
New Hampshire	326	471	168	596	71	524	0	474	116	555

Section 302: Repeal of gross income limitation

Present Law

Prior to the 1981 Reconciliation Act, there was no statutory limit on the amount of gross income a family could have and receive AFDC. In determining eligibility and benefit amounts, the earned income disregards (described above) were applied. Under the Reconciliation Act, eligibility for AFDC is limited to families with gross incomes (income before application of any disregards) at or below 150 percent of the State's standard of need.

Explanation of Provision

The provision limiting AFDC eligibility to families with income at or below 150 percent of the State standard of need would be repealed. As under prior law, eligibility and benefit amounts would be determined by applying the earned income disregards. The 150 percent limitation has had the effect in many instances of nullifying the effect of the earned income disregards. This has been particularly true for working mothers in States with low needs standards and whose earnings may exceed the 150 limit, but who must pay a substantial portion of their earnings for child care. The 150 percent limit has also penalized students and youth participating in certain CETA youth programs whose earnings may cause the family to lose AFDC eligibility, despite the general principle expressed elsewhere in the law that student earnings should not be counted in determining AFDC benefit amounts.

Section 302 would be effective October 1, 1982, or earlier at State option.

Section 303: Treatment of earned income credit

Present Law

Since 1975, the Federal Government has provided a tax credit for low-income workers with children. Under present law, an eligible individual is allowed a refundable credit equal to 10 percent of the first $5,000 of earned income, for a maximum credit of $500. The maximum credit is phased down as adjusted gross income (or, if greater, earned income) rises above $6,000, being reduced to zero for families with incomes over $10,000. Any individual who is married and entitled to a dependency exemption for a child, any surviving spouse, and any head-of-household who maintains a household for a child is generally eligible for the credit.

Since 1979, employees have been allowed to file an eligibility certificate with their employers for the purpose of receiving advance payment of the credit along with their regular wages, instead of at the end of the year after their tax return is filed. However, virtually no advance payments of EITC are actually made.

Prior to the 1981 Reconciliation Act, any amount of EITC *received* by an AFDC recipient was counted as earned income for purposes of AFDC, regardless of whether it was received as an advance payment or at the end of the year. The 1981 Reconciliation Act amended the statute to require States to count the amount of the earned income tax credit which is payable to an AFDC recipient on an advance basis. This amount must be counted whether or not it is actually received.

Explanation of Provision

The bill would restore prior law. Only the amount of earned income tax credit which is actually *received* by a family would be counted as earned income for purposes of determining AFDC benefits. Actual amounts received would be counted if received as an advance payment or at the end of the year.

Section 303 would be effective October 1, 1982, or earlier at State option.

Section 304: Exclusion from income

Present Law

Income received by an AFDC household is counted as income in determining both eligibility for an the amount of assistance unless such income is specifically excluded from being counted. In the past, the Department of Health and Human Services has not required that certain State payments be considered income for purposes of determining AFDC eligibility or amount of benefits. These are payments that have been financed wholly from State funds to meet needs of children receiving AFDC which are not met by the regular AFDC payment.

Prior to the Omnibus Budget Reconciliation Act of 1981, payments received by an AFDC unit were usually considered as income only in the month of receipt. Section 2304 of the Reconciliation Act required that certain countable income be considered as income not only in the month it is received, but also in future months. Thus, if such countable income in a month exceeds the standard of need, such income is applied in determining eligibility for, or the amount of, benefits in future months.

Explanation of Provision

Section 304 clarifies that totally State financed payments to AFDC children, that are provided to meet certain needs of the children and have been provided by the State on a continuous basis since before January 1, 1979, will continue to be excluded from income for purposes of determining eligibility for or the amount of the families' AFDC benefits. Furthermore, such State payments will not be counted as income in applying the provisions enacted under Section 2304 of the Omnibus Budget Reconciliation Act of 1981.

Section 304 would be effective October 1, 1982, or earlier at State option.

Section 305: Advance payment to States with respect to AFDC expenditures

Present Law

Under current law and regulations, Federal AFDC matching funds are distributed on the basis of grant awards, and the funds are generally available at the time a State issues checks or make payments under the program.

The Department of Health and Human Services is in the process of implementing new regulations that establish a "delay-of-drawdown" reimbursement system. Under this new system, a State would "drawdown" its allocation of federal AFDC funds on the basis of its historical check *clearance* patterns as determined by HHS. Such funds could not be drawn in excess of the previously determined percentage for a given day. In other words, Federal funds would no longer be available at the time State checks or warrants are issued, but at the time they clear the State depository.

Explanation of Provision

Section 305 provides that, if a State requests, Federal AFDC matching funds must be made available to the state at the time the state issues AFDC checks or otherwise makes expenditures.

The amendment further specifies that if the State draws AFDC matching funds in advance of the time checks or warrants issued with respect to the funds clear the State depository for payment, the Secretary may require that the funds be deposited in a separate bank account or in a separate designated account within the State treasury pending their use for payment of the checks or warrants. Furthermore, the State may be required to pay to the Secretary an amount equal to interest on the funds involved while they are (or should have been) deposited. The interest to be paid to the Secretary would be reduced by the amount needed to cover all additional administrative costs incurred by the State in connection with the new procedure. The interest rate applicable to the funds would be the rate based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during the period beginning with the date the funds were drawn by the State and ending when the checks or warrants clear the State depository and are then paid. Amounts paid to the Secretary by the State would be deposited into miscellaneous receipts of the Treasury.

The amendment also instructed OMB to report to the Committee on Ways and Means by July, 1983, on a consistent government-wide cash management policy and set of procedures, including provisions for the equitable reimbursement to the States of interest on funds they may advance to the federal government.

Section 305 is effective for Federal matching funds provided to a State for State AFDC expenditures in calendar quarters after the calendar quarter in which the bill is enacted.

Section 306: Job search

Present Law

Under present law, a State may not compel an AFDC *applicant* to particpate in a job search program or effort as a condition of AFDC eligibility. (Under special waiver authority, several States have been permitted to operate job search programs for applicants.) The Social Security Disability Amendments of 1980, however, included a provision specifically authorizing Federal matching for job search activities which are part of a State's work incentive program. Both the statute and the regulations provide sanctions if a *recipient* who is required to register for WIN and who has been certified as ready for employment refuses without good cause to participate in job search. In the case of the principal wage earner in an unemployed parent family, the sanction is denial of benefits for the entire family. In other cases, the individual who refuses is removed from the grant and the family's benefit is reduced. The sanction period is 3 months in the case of a first refusal and 6 months in the case of any subsequent refusals.

WIN requires the registration of all persons unless they are: children under age 16 or in school full time; ill, incapacitated, or elderly; too far from a project to participate; needed at home to care for

a person who is ill; a caretaker relative providing care on a substantially full-time basis for a child under age 6; employed at least 30 hours a week; or the parent of a child if the other parent is required to register (unless that parent has refused).

Explanation of Provision

Section 306 permits States to require employable AFDC applicants to participate in a program of employment search as a condition of AFDC eligibility. The persons who could be required to participate would include only those who are required to register for the WIN program, and persons who are currently excluded because they live in an area so remote from a WIN project that their participation is precluded. A State, however, could further limit the job search requirement to certain groups, types, or classes of individuals who are subject to the WIN requirement.

The employment search period would begin at the time of application and continue for a period (prescribed by the State) of not more than eight weeks. The State agency could also require an individual to participate in employment search at such tme or times after the close of the initial eight week period, but not to exceed a total of eight weeks in any twelve consecutive months.

A recipient who refuses without good cause to comply with the requirement for employment search would be subject to the same penalties as an individual who refuses to comply with other work requirements. However, the State could elect to shorten the duration of the penalty period.

The bill specifically provides that the job search requirement may not be used as a reason for any delay in making a determination of an individual's eligibility for aid or in issuing a payment to or in behalf of any individual who is otherwise eligible for aid. It is anticipated that the Department of Health and Human Services will monitor this program so as to assure that no State uses this requirement as a way of holding up consideration of an individual's AFDC application, or of denying or delaying payments otherwise due.

The bill also requires that any individual participating in a program of employment search must be furnished transportation and other services, or paid (in advance or by way of reimbursement) any amounts to cover transportation costs and other expenses reasonably incurred in order to enable the individual to participate in the employment search program. Federal matching for transportation and other services would be available to the States at the 50 percent rate applicable to other administrative costs.

There would have to be coordination by the State between the employment search program and other employment programs to assure that priority is given to job placement over participation in another activity.

Over 80 percent of the heads of AFDC families are women. Over half have a child under 6 and over 80 percent have at least one child under 12. They frequently live in the most economically depressed urban or rural areas of the country, lack high school degrees, have limited employment experience, and are members of minority groups. As a result, few appropriate private sector jobs

are available to them and they suffer severe disadvantages in competing for those that are. To the extent any private sector jobs are available to AFDC applicants and recipients, generally they are entry level, minimum wage jobs.

A number of provisions in H.R. 6878 are aimed at helping welfare recipients overcome these disadvantages. The most important provisions are those in sections 301 and 302 that significantly reduce the work disincentives that were built into the AFDC law by the 1981 Reconciliation Act, and restore positive work incentives. (These changes are described at length under sections 301 and 302.) The provisions for disregarding certain amounts of earned income will make it possible for an AFDC recipient to seek and accept a private sector job, even though it may be a relatively low-paying job, because the recipient will be assured of an increase, rather than facing a possible decrease in family income.

The employment search provision in this section should be viewed as a means of reinforcing the objective of, and State resources for, encouraging private sector employment for AFDC applicants and recipients. There have been a significant number of employment search demonstration programs in recent years which have shown that innovative, structured group job search programs can be effective in placing AFDC recipients in private jobs. A recent study done for the Department of Labor, entitled "Placement Assistance in the ES, WIN and CETA," found that "Taken as a whole * * * the findings are generally consistent, pointing to important positive conclusions concerning the efficacy of this [group job search] approach. The study, which analyzed the experience of the Employment Service, WIN and CETA programs with various forms of job placement assistance, concluded:

> In the short run (that is, within one or two months after the program) people assigned to group job search are more likely to find employment than persons receiving other forms of job search assistance. Among the studies for which control group data were available, an average of 68 percent of the group job search assignees found jobs within one or two months after the program. An average of only 33 percent of the control group members found employment within this period.

Other demonstration and pilot programs have resulted in positive findings from group job search activities. An important example is the Employment Opportunities Pilot Program developed by the Department of Labor in the late 1970's which involved a mandatory 8-week intensive job search program for AFDC recipients at 14 sites throughout the Nation. Another example is the demonstration of the job club method of finding jobs for WIN registrants which was conducted by the Anna Mental Health and Developmental Center. This demonstration, which was conducted in Harlem, New Brunswick, Tacoma, Wichita and Milwaukee, resulted in the placement of 62 percent of the job club participants. The report of findings states that the job club method was effective for all types of recipients, even in areas of high unemployment.

Upon enactment of this section, it would be anticipated that the Administration will draw upon these prior experiences in assisting

the States to develop and operate effective job search programs. The administration should make every effort to provide technical assistance to those States that elect to develop job search programs. This should include manuals to help train staff in how to operate an effective program, resource materials which describe other States' experiences, training sessions, and such other methods as will enable the States to assist welfare applicants and recipients in competing for private sector jobs.

Section 306 is effective upon enactment.

Section 307: Exclusion from income of certain State payments

Present Law

A provision in the 1981 Reconciliation Act required States to determine AFDC benefits on the basis of the family's income in the preceding month. Under certain circumstances, payment may be determined on the basis of income in the second preceding month. This may be necessary, for example, when the payment date is in the first week of the month and the State needs time to process the monthly report of income which must be submitted by the recipient.

A State which has such a lag between the month for which income is counted and the payment date may wish to supplement the AFDC payment with a wholly State-financed payment. It may choose to do this, for example, for families which lose employment and suffer an immediate loss in income. Under present law, however, if the State decides to assist a family during a payment adjustment lag, any supplement which it pays to the family is counted as income for purposes of determining the AFDC benefit. This has the effect of reducing the next AFDC benefit check and the State may find that it must supplement the AFDC benefit again in order to meet the family's needs. The fact that the State supplementary payment must be counted as income for AFDC establishes a cycle which may force the State to supplement the AFDC benefit on a continuing basis.

Explanation of Provision

Section 307, for purposes of determining a family's AFDC benefit, excludes State funded payments received by the family in a previous month that were intended to make up the difference between the State determined needs of the family and the amount of AFDC paid, where such a difference occurs because of the lag period under the required retrospective accounting procedures. This provision allows States to provide compensation for a reduction in income that occurs during the lag period resulting from retrospective accounting, or during the period before a new benefit amount reflecting changes that have occurred in a family's circumstance can be paid, without such compensation reducing the family's AFDC payment in subsequent months.

Section 307 is effective upon enactment.

Section 308: Cost of services for non-AFDC families

Present Law

Under present law, States are required to provide child support services to both AFDC and non-AFDC families. States receive 75 percent matching funds for their costs of providing services.

Prior law allowed States to recover costs of serving non-AFDC families by charging an application fee of up to $20, and by retaining a portion of any child support payments it collected. Last year, the Administration proposed replacing this optional provision with a requirement that States retain a fee equal to 10 percent of the support collected. In the Reconciliation Act, the Congress amended this provision to require that the fee be charged against the absent parent, rather than the custodial parent, and that the fee be added to the amount of the collection. States have reported to the Committee that because of legislative barriers and administrative difficulties, they have generally been unable to implement the requirement.

Explanation of Provision

States could elect to recover costs of services provided to non-AFDC families by deducting the costs from the amount of any recovery made (that is, from the amount due to the custodial parent and/or any children), or from the parent who owes the child or spousal support obligation. The costs of collection could be determined by the State on a standardized basis, in accordance with criteria prescribed by the Secretary. No amount could be deducted as costs that exceeds 10 percent of the amount of the support collected. If the State elects not to recover the costs of services to non-AFDC families, it must pay the cost of these services from State funds.

Section 308 would be effective October 1, 1982.

Section 309: Reduction in certain Federal payments to States under the child support enforcement program

Present Law

Under the child support enforcement program (Title IV-D of the Social Security Act), States are required to assist both AFDC and non-AFDC families to locate absent parents, establish paternity, and establish and collect child support payments.

Applicants for, and beneficiaries of, AFDC are required to make an assignment of support rights to the State in order to receive AFDC. In addition, each applicant or recipient must cooperate with the State if necessary to establish paternity and secure child support.

The act provides for 75 percent Federal financial participation in the administrative costs incurred by the State in providing child support services. This includes costs incurred by law enforcement officials pursuant to cooperative agreements with the IV-D agency and costs of supportive or administrative personnel of courts in the performance of IV-D functions. On July 1, 1981, Federal matching was made available to cover 90 percent of the cost of developing

and implementing child support management information systems. In addition, a 15 percent incentive payment, financed entirely from the Federal share of AFDC collections, is paid to States.

Explanation of Provisions

Section 309 reduces the Federal matching rate for State and local administrative costs for child support services from 75 percent to 65 percent. In addition, the incentive payment paid to States from the Federal share of child support collections is reduced from 15 to 12 percent. Also, there would no longer be matching funds provided for the costs of administrative personnel of courts who perform child support enforcement functions related to the child support program. Matching for the development and implementation of approved management information systems would be continued at the 90 percent rate.

The objectives and achievements of the IV-D child support enforcement program are fully supported. The reduction in Federal funds contained in this section does not indicate any change in the commitment to the continuation and strengthening of the program.

There is concern, however, regarding the wide diversity in the cost effectiveness of the program among States. For example, according to information provided by the Administration, in fiscal year 1981 twelve States accounted for 87 percent of national welfare savings attributable to IV-D child support enforcement activities. These same States account for only 16 percent of fiscal year 1981 national administrative expenditures.

There is also concern about the growing net cost of the program to the Federal government. The Administration estimates that the net Federal costs of the program (i.e., the Federal share of child support collections minus Federal administrative and incentive payments to States) will increase from $153.0 million in fiscal year 1981 to $224.0 million in fiscal year 1984.

The reductions in Federal funds for the IV-D child support enforcement activities are necessary in order to reduce the increasing net Federal cost of the program. In a period such as this, when Federal outlays for domestic programs are being drastically reduced, it is imperative that the reductions be spread out among all Federally supported programs as evenly as possible, without doing major damage to the operations and effectiveness of specific programs.

The small reductions in different parts of the program contained in this section are prefereable to the major restructuring of the Federal IV-D financing procedures proposed by the administration. It should be easier for States to adjust to incremental modifications contained in this bill than to the major restructuring proposed by the Administration.

This reduction in Federal child support administrative and incentive funds should encourage States to increase and improve their support collection efforts in order to compensate for this reduction in Federal funds.

Section 309 would be effective October 1, 1982.

Section 310: Allotments from pay for child and spousal support owed by members of the uniformed services on active duty

Present Law

Present law does not provide for allotments from the pay and allowances of members of the U.S. uniformed services for child support obligations.

Explanation of Provision

Section 310 amends Title IV-D of the Social Security Act, which authorizes the child support enforcement program to require allotments from the pay and allowances of any member of the uniformed service on active duty who fails to make child (child or spousal) support payments. The requirement would arise when the member failed to make support payments in an amount at least equivalent to the value of two months' support. Provisions of the Consumer Credit Protection Act would apply so that the percentage of the member's pay which could be subject to allotment would be limited. The amount of the allotment would be that of the support payment, as established under a legally enforceable administrative or judicial order. It would be required that the service member be given notice of the support order and the allotment to cover amounts in the order, and that he be given an opportunity to receive legal advice before any allotment occurs.

Section 310 would be effective October 1, 1982.

Section 311: Reimbursement of State agency in initial month of ineligibility for AFDC

Present Law

Under the child support enforcement program, States are required to collect child (or child and spousal) support on behalf of families who are receiving AFDC. The statute currently requires that amounts of support collected which are sufficient to make the family ineligible for AFDC must be paid to the family beginning with the first month of ineligibility.

Explanation of Provision

Section 311 provides that amounts collected which are sufficient to make the family ineligible would be paid to the family in months after the first month of ineligibility. This would allow the State to reimburse itself for AFDC that would have already been paid for that month before the support was collected and known to make the family ineligible. Thus, the family would not receive double payment for the same month, both in the form of AFDC and through receipt of the support collection.

Section 311 would be effective upon enactment.

TITLE IV—SUPPLEMENTAL SECURITY INCOME PROGRAM

Section 401: Supplemental security income accounting period

Present Law

Under the SSI law in effect through March 1982, computation of SSI eligibility and amount of benefits was based on the income and resources for the current calandar quarter. The Omnibus Budget Reconciliation Act of 1981 required that, after March 1982, the computation period for determination of eligibility and amount of SSI benefits be on a *monthly* rather than a quarterly basis. The new provisions require that *benefits*, generally, be determined on a monthly *retrospective* basis. That is, the amount of the SSI benefit for any month will be determined on the basis of the individual's or couple's income, resources, and other circumstances in the preceding month or, at the discretion of the Secretary of Health and Human Services, the second preceding month. The SSI payment received in August 1982, for example, will not reflect the amount of any other income the recipient had in August, it will reflect the amount of any such income the person received in June.

Explanation of Provision

Section 410 returns SSI to a *prospective* or current month accounting system. The section does maintain a *monthly* accounting period, rather than a quarterly period as in the law prior to the 1981 Reconciliation Act.

The objective of the 1981 Reconciliation Act change to a *retrospective* accounting procedure was to reduce program costs by reducing the number of erroneous payments. Because benefits are computed on the basis of the recipient's *actual* income in a prior month, rather than *projected* income for a current or future month, it was assumed that retrospective accounting would reduce errors, and thereby reduce SSI costs.

In fact the retrospective accounting procedure required under the Reconciliation bill increased rather than decreased SSI costs. Furthermore, it created an erratic fluctuation in SSI benefits for those SSI recipients who also receive Social Security payments or other automatically adjusted benefits such as Veterans' Black Lung or Railroad Retirement benefits. In addition, it is highly questionable as to how much if any savings would be achieved through a reduction in errors.

The reason retrospective accounting does not produce the savings assumed in the Reconciliation bill is that approximately 90 percent of all non-SSI income recieved by SSI recipients is Social Security benefits; and, another 2 percent is Veterans, Railroad Retirement or Black Lung Benefits. Only 3 percent of all non-SSI income received by SSI recipients is from earnings.

In other words, 92 percent of all non-SSI income is from Federal programs, the benefits of which are increased once a year according to automatic cost-of-living provisions that reflect changes in the Consumer Price Index. Information on the amount of the annual adjustment in the payments under these programs is available to the Social Security Administration, which administers the SSI pro-

gram. Because the Social Security Administration has access to information on almost all of the fluctuation that occurs in the non-SSI income of SSI recipients, the primary justification for a retrospective accounting period—to achieve a reduction in errors by obtaining more accurate information on fluctuations in other income—has little relevance in the case of the SSI program.

Under a retrospective accounting system, which computes benefits on the basis of recipient income in prior months, Social Security, Veterans and other Federal benefit increases will not be counted as income in the first months that they are received. Therefore, SSI payments in July and August, increased by cost-of-living adjustments in the SSI program, will not reflect similar increases in Social Security, Veterans and other Federal pensions. SSI recipients receiving these other benefits will be paid two months of SSI payments each year that do not take into account actual increases in these automatically adjusted pensions. For these two months, SSI recipients will, in effect, be overpaid. However, in September and months thereafter, SSI payments will be reduced because of the increased Social Security or other Federal benefits. In other words, a person's SSI check will be increased in July and August and then decreased (but remaining higher than the amount received in June) in September. These changes in the amount of a person's SSI check (3 different amounts in a four-month period) will result in substantial confusion among SSI recipients.

Waiting two months to count new income or increases in Federal pensions that are known and predictable (such as the yearly automatic increase in Social Security benefits) will increase SSI expenditures over what they would have been under the law prior to the Reconciliation bill. The Administration estimates that not counting Social Security increases for two months will increase SSI costs by approximately $50 million in fiscal 1982. The Congressional Budget Office estimates that this two-month delay resulting from retrospective accounting will increase SSI costs by $69 million in fiscal 1982. The State of California estimates that, in addition to the increase in Federal costs, retrospective accounting will increase California's expenditures for SSI supplemental payments by $16.4 million in fiscal 1982. There will be similar cost increases in other States that supplement the Federal SSI payment. These cost increases will be repeated each year, with the amount of the increase depending upon the percentage increase in Social Security and other automatically adjusted benefits.

It is highly questionable as to how much savings will result from a decrease in erroneous payments under retrospective accounting; certainly nowhere near the amount that will be lost due to the two-month delay in counting increases in Social Security and other benefits. Currently, most SSI erroneous payments are caused by recipients' failure to report changes in circumstances and agency caused errors, neither of which will necessarily be corrected through retrospective accounting. It appears that a limited reduction of erroneous payments would only slightly reduce the increased costs associated with the retrospective accounting system mandated by the Reconciliation bill.

The amendments in section 401 will return SSI to a "prospective" accounting system, which will allow SSI payments to be adjusted to take account of increases in Social Security and other indexed benefits the first month in which the recipient receives any other indexed benefits.

Most important, section 401 will return SSI accounting procedures to a system where benefits reflect the *current* circumstances and needs of the aged, blind or disabled individual or couple. In other words, the SSI payment received in August will reflect the circumstances and needs of the individual or couple for the month of August; rather than being based on their circumstances, which may or may not still be relevant, in June.

Extra income that was available to the individual or couple one month may not still be available two months later. Under the current retrospective system, however, the person's SSI benefit is reduced two months later by the amount of that extra income, even if it is no longer available to the person. This means the person will be faced with paying that month's rent, food, energy, medical, and other bills with a reduced SSI payment because of the extra income he or she received in June. If that extra income has been spent, as it very well may be, the person simply may be unable to meet his or her basic needs for the month, which is contrary to the primary purpose of the SSI program.

Section 401 would be effective on and after the third month after the month of enactment.

Section 402: Phase-out of "hold harmless" protection

Present Law

SSI provides for a basic Federal minimum payment to all recipients. States are allowed to supplement the Federal payment. The original 1972 SSI statute included "hold harmless" protection for the States. This allowed States to supplement the Federal payment to assure that recipients would receive cash benefits equal to their January 1972 benefit levels, with no cost to the State beyond what it spent for benefits on behalf of aged, blind and disabled persons in 1972.

Because of Federal benefit increases since enactment of SSI, all except two States, Hawaii and Wisconsin, have lost their "hold harmless" status. These two States will receive a Federal contribution to their State supplements because of a special provision added to the law in 1976. Under this provision, their "hold harmless" payments are no longer reduced by Federal benefit increases.

The 1982 Continuing Resolution for fiscal year 1982 provided for a reduction in the "hold harmless" payment for Wisconsin and Hawaii in fiscal year 1982.

Explanation of Provision

Section 402 continues phasing out "hold harmless" payments for the two remaining States as follows: The "hold harmless" payment would be reduced to 40 percent of what it would otherwise be in 1983, to 20 percent in 1984, and no "hold harnmless" payments would be made in or after 1985.

Section 402 would be effective upon enactment.

Section 403: Exclusion from resources of burial plots and certain funds set aside for burial expenses

Present Law

Under present law, SSI recipients may retain countable liquid resources of up to $1,500 for an individual and $2,250 in the case of a eligible couple.

There are certain types of resources which are not counted toward these limits. Within limits set by regulations, the value of household goods, certain personal effects and an automobile are not counted. Also exluded is an SSI applicant's or recipient's home which is their place of residence, and property essential for self support.

In the case of life insurance policies, if the total face value of all policies of an SSI applicant or recipient is $1,500 or less, the cash value of such policies is totally excluded from being counted toward the liquid resources limits. If the total face value of all policies on any individual exceeds $1,500, the entire cash surrender value of such policies is counted toward the liquid resources limits. The intent of the $1,500/$2,250 liquid assets provisions is to enable the aged, blind or disabled individual or couple to maintain a small cash reserve for emergency situations which cannot be met with the monthly SSI check. In addition, life insurace policies with only $1,500 face value or less are usually intended as funds to be used to meet the future burial expenses of the individual even if the policy has some cash surrender value.

The Social Security Administration has interpreted the current SSI statute to define resources as only those which could be converted to cash during the lifetime of the individual. This interpretation has a different impact on SSI applicants or recipients in the case of prepaid burial contracts depending on the law of their respective States.

In about one-half of the States there are laws which require all prepaid burial contracts to be revocable. That is, the buyer of such a contract in those States is entitled to a refund. Under present SSI law, revocable prepaid burial contracts are considered a liquid resource and are counted toward the $1,500/$2,250 liquid resources limit. Some individuals have chosen to set aside funds in a separate bank account or revocable trust with the intent that such funds are to be used for their burial. Such funds are not exempt under present SSI law from being counted as a liquid resource.

Under present law, the fair market value of cemetery property or other burial spaces is also a countable liquid resource in determining eligibility for SSI.

Term life insurance policies, burial insurance, irrevocable trusts and irrevocable burial contracts do not have any cash value to SSI recipients during their lifetime and therefore current SSI regulations provide that they are not counted toward either the SSI liquid resources limit or the life insurance face value limit in determining eligibility for SSI.

Explanation of Provision

Section 403 adds to the current resource exclusions in SSI law the value of a burial space held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family. In addition, the proposed amendment would provide that an SSI applicant or recipient could have exempted from being counted as a liquid resource up to $1,500 each for the individual and his spouse of separately identifiable funds set aside for burial expenses.

The $1,500 limit on the amount of funds which may be set aside for burial purposes under the provision of the amendment would be reduced on a dollar for dollar basis by the face value of life insurance policies (with cash value) that has been excluded, which may be owned by the SSI applicant or recipient, and by the value of any irrevocable trust or arrangement that has not been counted as a resource. The separately identifiable funds set aside for burial purposes could be, for example, in a separate bank account, in a revocable trust or in a revocable burial contract.

Therefore, the amendment would enable aged, blind or disabled individuals in States which do not allow irrevocable burial contracts to qualify for SSI benefits even if the value of the contract would cause the value of their liquid resources to exceed the liquid resources limit of $1,500 for an individual or $2,250 for a couple.

The amendment would overcome the inequity among SSI recipients created by differences among State laws and also ensure that aged, blind and disabled individuals will not have to choose between being eligible for needed income assistance from SSI and having the assurance that their relatives or the State or local government will not have to pay for their burial.

Funds set aside in separate bank accounts, revocable burial contracts or trusts are potentially available to the SSI applicant or recipient. However, the amendment provides that if funds, previously excluded from resources are drawn out and spent by the SSI recipient for purposes other than to meet future burial expenses, future SSI benefits payable to the SSI recipient would be reduced by a like amount. Only that portion of the value of the separate burial fund which, when added to the individual's or couple's countable liquid resources, exceeds the $1,500/$2,250 liquid resources limit would be subject to being counted as income if used for purposes other than to meet future burial needs.

The amendment preserves the provision in present law and regulations which exempts from being counted either as a liquid resource or counted toward the $1,500 life insurance face value limit the value of any burial insurance or term life insurance which will not have a cash value during the lifetime of the recipient. However, the amendment does provide that the $1,500 limit on separately identifiable funds set aside for burial purposes under the new option would be reduced on a dollar for dollar basis by the value of any such burial insurance, irrevocable trust, or burial contract.

Included in that portion of the amendment that exempts from being counted as a resource the value of burial spaces is authority for the Secretary of Health and Human Services to establish limits as to the size or value of such burial spaces. As under current law,

related to the exclusion of the value of household goods, personal effects and automobiles, the Secretary will be expected to adjust the allowable value limits to reflect increases caused by inflation or other factors. The term "burial spaces" used in the amendment covers all methods of interment, including ground burial, niches for cremated remains and mausoleum entombment.

Excluding the value of burial plots or other burial places will prevent such situations as an aged individual having to choose between SSI benefits or giving up a burial space next to their deceased spouse or other close family member.

Section 403 would be effective on the first day of the second month after the month of enactment.

Section 404: Mandatory pass-through under State supplementation provision

Present Law

Since July 1977, States which supplement Federal SSI benefits have been required to pass-through the Federal SSI cost-of-living increases. A State may meet this requirement by one of two options. The first option is to maintain the December 1976 level of State supplementation payment for recipients. The second option is for a State to provide in a twelve-month period, no less than the total aggregate amount of State supplementation paid by the State in the previous 12-month period. Some States chose the aggregate amount option because they did not want to provide for a cost-of-living increase for residents of non-medical domiciliary care facilities. Some States which originally chose to meet the pass-through requirements under the second option (i.e., total aggregate amount of State supplementation) now wish to switch to the first option because of the declining number of SSI recipients in the State. However, in order to switch to the first option the State would have to build into the State supplementation payment levels all of the funds that they would have paid out if, since 1977, they had elected to meet the "payment-level" pass-through requirement.

Explanation of Provision

Section 404 allows a State to shift from the aggregate spending option to the State supplementation payment level option, if the State does not decrease the State supplementation payment level below the previous year's level.

Section 404 would be effective July 1, 1982.

IV. BUDGET IMPACT AND COST ESTIMATES

Tables 1 and 2 summarize the impact of H.R. 6878 upon the budget. The estimates in these tables include the impact of the regulatory changes that the Administration recommended and which were included as policy assumptions in the first budget resolution in determining the reconciliation instruction to the Committee on Ways and Means. These estimates are shown in footnote b in the Congressional Budget Office letter which follows.

As shown in Table 1, H.R. 6878 would reduce the deficit by $4.864 billion in fiscal year 1983, and by $20.134 billion over the 3-year period from 1983 to 1985. Table 2 shows the impact upon the deficit for each of the major provisions.

TABLE 1.—SUMMARY IMPACT OF H.R. 6878 UPON BUDGET DEFICIT

[In millions of dollars]

	Fiscal year			Total
	1983	1984	1985	
Medicare	−3,261	−4,192	−4,620	−12,073
AFDC/CSE	−106	−128	−130	−364
SSI	−48	−59	−67	−174
Unemployment compensation	−1,449	−2,895	−3,188	−7,532
Total	−4,864	−7,274	−8,005	−20,143

Note.—All numbers are CBO estimates. The estimates include the total budget impact of each provision. Thus the savings included under medicare include the medicaid savings resulting from the hospital reimbursement changes. Similarly the AFDC work incentive amendments include the food stamp savings and medicaid cost which would result from enactment of this provision.

TABLE 2.—IMPACT OF H.R. 6878 UPON BUDGET DEFICIT INCLUDING BOTH OUTLAYS AND REVENUES

[In millions of dollars]

[+ indicates an increase in the budget deficit; − indicates a decrease in the budget deficit.]

	Fiscal year 1983	Fiscal year 1984	Fiscal year 1985	Total
1. Mandate increased auditing ($45 m)	−130	−300	−300	−730
2. Recognize implementation of administration's planned regulatory actions	−625	−804	−920	−2,349
a. Improve contractor utilization review activities	(−330)	(−385)	(−440)	(−1,155)
b. Eliminate percentage contracts for radiologists, pathologists, and others	(−63)	(−73)	(−84)	(−220)
c. Eliminate duplicate payments for physicians in hospital outpatient departments	(−160)	(−225)	(−270)	(−655)
d. Eliminate subsidy for private hospital rooms	(−54)	(−75)	(−80)	(−209)
e. Set single reimbursement limits for hospital-based and free-standing SNF and home health agencies	(−18)	(−46)	(−46)	(−110)
3. Periodic interim payments	−750	−100	+870	+20
4. Provide reimbursement for hospice service	+3	+1	−17	−13
5. Limit reimbursement for assistants at surgery	−55	−130	−150	−335
6. Require interest on overpayments to providers	−25	−25	−20	−70
7. Offset Hill-Burton free care	−15	−17	−20	−52
8. Prohibit reimbursement for antiunion organizing activities	0	0	0	0
9. Eliminate the 3-day prior hospitalization requirement	0	0	0	0

TABLE 2.—IMPACT OF H.R. 6878 UPON BUDGET DEFICIT INCLUDING BOTH OUTLAYS AND REVENUES—Continued

[In millions of dollars]

[+ Indicates an increase in the budget deficit; − Indicates a decrease in the budget deficit.]

	Fiscal year 1983	Fiscal year 1984	Fiscal year 1985	Total
10. Mandate medicare coverage for Federal workers	−739	−1,000	−1,103	−2,842
11. Change hospital reimbursement to an incentive reimbursement system with limits on a per admission basis and expand section 223 limits to include total operating costs	−910	−1,800	−2,940	−5,650
12. Reform reimbursement to HMO's	0	0	0	0
13. Voluntary medicare voucher	0	0	0	0
14. Lower of costs or charges	0	0	0	0
15. Prohibit medicare payments when based upon percentage arrangements	−15	−17	−20	−52
16. Extend medicare proficiency examination authority	0	0	0	0
17. Prohibit retroactivity of regulations regarding access to books and records	0	0	0	0
Total—medicare	−3,261	−4,192	−4,620	−12,073
AFDC/CSE				
18. AFDC work incentive amendments	+71	+112	+142	+325
19. Require States to recover administrative costs of non-AFDC CSE collections	−45	−51	−59	−155
20. Restructure CSE financing arrangements	−147	−165	−183	−495
21. Require Federal AFDC moneys be available to States when State issues AFDC checks	+30	+1	+1	+32
22. Assign wages for members of the Armed Forces	−7	−9	−10	−26
23. Allow States to require job search for AFDC applicants	−5	−10	−15	−30
24. Allow States to exclude certain State payments	0	0	0	0
25. Allow States to coordinate AFDC benefits and child support payments in final month of eligibility	−3	−4	−4	−11
26. Impact upon the food stamp and medicaid programs	0	−2	−2	−4
Total	−106	−128	−130	−364
SSI				
27. Coordination of COLA's with SSI (establish 1-month prospective accounting	−25	−30	−30	−85
28. Phase out "hold harmless" protection	−30	−37	−45	−112
29. Exclude burial plots and accounts from SSI eligibility calculations	+5	+5	+5	+15
30. Optional alteration of State supplemental pass-through	0	0	0	0
31. Impact upon the food stamp and medicaid program	+2	+3	+3	+8
Total	−48	−59	−67	−174
Unemployment compensation				
32. Additional weeks of unemployment compensation	+562	0	0	+562
33. Lower income thresholds for taxation of unemployment compensation	−696	−686	−611	−1,993
34. Assist States to provide UC benefits to partially unemployed workers	+1	+1	0	+2
36. Allow States to deny UC benefits to nonprofessional employees of institutions of higher learning	−7	−8	−9	−24
37. Increase FUTA revenues	−1,404	−2,353	−2,857	−6,614
38. Modification of credit reduction in 5th year of State loan	0	0	+127	+127
39. Allow States to reduce interest payments on loans	+95	+151	+162	+408
Total	−1,449	−2,895	−3,188	−7,532

Note: All numbers are CBO estimates. The estimates include the total budget impact of each provision. Thus the savings included under medicare include the medicaid savings resulting from the hospital reimbursement changes. Similarly the AFDC work incentive amendments include the food stamp savings and medicaid cost which would result from enactment of this provision.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Alice M. Rivlin
Director

July 29, 1982

The Honorable Dan Rostenkowski
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

Pursuant to Section 202 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 6878, a bill to amend the Social Security Act to make changes in the medicare, unemployment compensation and public assistance programs and for other purposes.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

for Alice M. Rivlin
Director

cc: The Honorable Barber B. Conable
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE

COST ESTIMATE

July 29, 1982

1. BILL NUMBER: H.R. 6878.

2. BILL TITLE:

The Medicare, Unemployment Compensation and Public Assistance Amendments of 1982.

3. BILL STATUS:

As introduced in the House on July 28, 1982.

4. BILL PURPOSE:

To amend the Social Security Act to make changes in the medicare, unemployment compensation and public assistance programs and for other purposes.

5. COST ESTIMATE:

TABLE 1. SUMMARY OF SPENDING EFFECTS OF H.R. 6878 AS INTRODUCED IN THE HOUSE ON JULY 28, 1982

		1983	1984	1985	1986	1987
		(By fiscal year, in millions of dollars)				
A. REVENUE INCREASES (NET)		2,717	3,876	4,268	4,005	3,314
B. SPENDING REDUCTIONS (DIRECT SPENDING)	BA	-975	-1,265	-1,452	-1,677	-1,863
	O	-2,809	-3,544	-3,867	-5,619	-6,937
C. SPENDING INCREASES (DIRECT SPENDING)	BA	3,462	4,391	5,744	6,231	6,900
	O	875	329	365	44	143
D. SPENDING DECREASES (AUTHORIZATIONS)	BA	-91	-53	-61	-62	-62
	O	-91	-53	-61	-62	-62
E. SPENDING INCREASES (AUTHORIZATIONS)	BA	478	640	709	814	888
	O	503	674	746	857	935
TOTAL SPENDING CHANGES	BA	2,874	3,913	4,940	5,306	5,863
	O	-1,522	-2,594	-2,817	-4,780	-5,921
TOTAL DEFICIT REDUCTIONS		4,239	6,470	7,085	8,785	9,235

TABLE 1A. DETAILS OF REVENUE EFFECTS

		1983	1984	1985	1986	1987
		(By fiscal year, in millions of dollars)				
HI tax on federal employees		617	837	927	1,066	1,163
Reduction of thresholds for income taxation of unemployment benefits	Revenues	696	686	611	618	650
Unemployment Insurance tax increases						
Increase federal unemployment tax	Revenues	1,404	2,353	2,857	2,817	2,554
Modification of credit reduction in fifth year of state loan	Revenues			-127	-496	-1,053
TOTAL - REVENUE CHANGE		2,717	3,876	4,268	4,005	3,314

TABLE 1B. DETAILS OF DIRECT SPENDING REDUCTIONS

			1983	1984	1985	1986	1987
			(By fiscal year, in millions of dollars)				
Medicare (Function 550)							
Mandate increased auditing	HI	BA	a/	a/	a/	a/	a/
		O	-130	-300	-300	—	—
Recognize Administration's planned regulatory actions b/							
Postpone periodic interim payments	HI	BA	a/	a/	a/	a/	a/
		O	-750	-100	870	—	—
Limit reimbursement for assistants at surgery	SMI	BA	-33	-38	-44	-49	-54
		O	-55	-130	-150	-175	-195
Require interest on overpayments to providers	HI	BA	a/	a/	a/	a/	a/
		O	-25	-25	-20	-20	-20
Prohibit reimbursement for Hill-Burton required free care	HI	BA	a/	a/	a/	a/	a/
		O	-15	-17	-20	-23	-26
Prohibit reimbursement for costs of influencing employees regarding unionization	HI	BA	—	—	—	—	—
		O	—	—	—	—	—
Hospital reimbursement provisions	HI	BA	a/	a/	a/	a/	a/
		O	-870	-1,720	-2,810	-3,740	-4,850
Payments to HMOs		BA	c/	c/	c/	c/	c/
		O	c/	c/	c/	c/	c/
Medicare vouchers		BA	c/	c/	c/	c/	c/
		O	c/	c/	c/	c	c/
Prohibit reimbursement where costs are based on percentage arrangements	HI	BA	a/	a/	a/	a/	a/
		O	-15	-17	-20	-23	-26
Extend proficiency examination authority		BA	*	—	—	—	—
		O	*	—	—	—	—
Prohibit retroactive application of regulations regarding access to books and records	HI	BA	—	—	—	—	—
		O	—	—	—	—	—
Total - Medicare		BA	-33	-38	-44	-49	-54
		O	-1,860	-2,309	-2,450	-3,981	-5,117

TABLE 1B. Continued

		1983	1984	1985	1986	1987
		(By fiscal year, in millions of dollars)				
Medicaid (Function 550)						
Hospital reimbursement provisions	BA	-40	-80	-130	-180	-230
	O	-40	-80	-130	-180	-230
Aid to Families With Dependent Children (AFDC) (Function 600)						
Optional job search for new applicants	BA	-5	-10	-15	-15	-15
	O	-5	-10	-15	-15	-15
AFDC impact of unemployment compensation proposals	BA	-23	0	0	0	0
	O	-23	0	0	0	0
Total - AFDC	BA	-28	-10	-15	-15	-15
	O	-28	-10	-15	-15	-15
Child Support Enforcement (CSE) (Function 600)						
Require states to cover costs for Non-AFDC families	BA	-45	-51	-59	-66	-76
	O	-45	-51	-59	-66	-76
Alter federal matching of administrative costs	BA	-147	-165	-183	-206	-229
	O	-147	-165	-183	-206	-229
Assign wages for members of the armed forces	BA	-7	-9	-10	-10	-10
	O	-7	-9	-10	-10	-10
Reimburse state agencies for ineligible AFDC families	BA	-3	-4	-4	-5	-5
	O	-3	-4	-4	-5	-5
Total - CSE	BA	-202	-229	-256	-287	-320
	O	-202	-229	-256	-287	-320
Supplemental Security Income (SSI) (Function 600)						
Coordinate cost of living adjustments (one-month prospective accounting)	BA	-25	-30	-30	-30	-30
	O	-25	-30	-30	-30	-30
Phase out "Hold Harmless"	BA	-30	-37	-45	-45	-45
	O	-30	-37	-45	-45	-45
Optional alteration of state supplement pass-through	BA	0	0	0	0	0
	O	0	0	0	0	0
Total - SSI	BA	-55	-67	-75	-75	-75
	O	-55	-67	-75	-75	-75

TABLE 1B. Continued

		1983	1984	1985	1986	1987
		(By fiscal year, in millions of dollars)				
Unemployment Compensation (Function 600)						
Allow states to deny unemployment benefits to non-professional employees of institutions of higher education	BA	—	—	—	—	—
	O	-7	-8	-9	-10	-11
Employers Share Employee Retirement (Function 950)	BA	-617	-841	-932	-1,071	-1,169
	O	-617	-841	-932	-1,071	-1,169
TOTAL DIRECT SPENDING REDUCTIONS	BA	-975	-1,265	-1,452	-1,677	-1,863
	O	-2,809	-3,544	-3,867	-5,619	-6,937

*Less than $1 million.

a/ Budget authority shown under spending increases.

b/ The Committee print recognizes the following planned Administration regulatory actions. If completed, these actions are estimated to save the following amounts from baseline. This footnote has been included at the request of Committee staff.

			1983	1984	1985	1986	1987
			(By fiscal year, in millions of dollars)				
Utilization review initiative	HI	BA	12	41	82	127	174
		O	-267	-322	-377	-437	-502
	SMI	BA	-16	-16	-16	-16	-16
		O	-63	-63	-63	-63	-63
Tighten reimbursement for hospital-based physicians	SMI	BA	-18	-21	-24	-27	-30
		O	-63	-73	-84	-96	-108
Eliminate duplicate payment for overhead on outpatient services	SMI	BA	-56	-68	-81	-95	-111
		O	-160	-225	-270	-325	-380
Eliminate private room subsidy	HI	BA	2	9	18	27	36
		O	-54	-75	-80	-85	-90
Establish single reimbursement limit for SNF and HHA services	HI	BA	1	4	9	14	20
		O	-18	-46	-46	-52	-58
TOTAL		BA	-75	-51	-12	30	73
		O	-625	-804	-920	-1,058	-1,201

c/ Effect cannot be estimated because implementation depends on development of a methodology not now available intended to assure actuarial equivalence in the age adjusted per capita cost. Once implemented, the provision would have small costs or savings depending on the success of the methodology to be developed.

TABLE 1C. DETAILS OF DIRECT SPENDING INCREASES

			1983	1984	1985	1986	1987
			(By fiscal year, in millions of dollars)				
Medicare (Function 550)							
Reimbursement for hospice services under medicare	HI	BA	*	*	*	3	5
		O	3	1	-17	-40	*
Eliminate lower of costs or charges requirement	HI	BA	d/	d/	d/	d/	d/
		O	d/	d/	d/	d/	d/
Elimination of the 3-day prior hospitalization requirement	HI	BA	d/	d/	d/	d/	d/
		O	d/	d/	d/	d/	d/
Impose HI tax on federal employees (eligibility change)		BA	*	*	-1	-2	-4
		O	1	5	10	15	21
(tax change)		BA	1,276	1,875	2,263	2,759	3,182
Increase in HI Budget Authority Resulting from Outlay Savings							
Mandate increased auditing		BA	6	27	61	79	82
Postpone periodic interim payments		BA	2	75	49	10	10
Require interest on overpayments to providers		BA	1	4	6	9	11
Prohibit medicare reimbursement for Hill-Burton required free care		BA	1	2	4	7	9
Hospital reimbursement provisions		BA	40	165	415	755	1,175
Prohibit reimbursement where costs are based on percentage arrangements		BA	1	2	4	7	9
Subtotal HI Budget Authority		BA	51	275	539	867	1,296
Total - Medicare		BA	1,327	2,150	2,801	3,627	4,479
		O	4	6	-7	-25	21
Aid to Families with Dependent Children (AFDC) (Function 600)							
Liberalize Earnings Disregards (H.R. 6369)		BA	103	133	158	159	159
		O	103	133	158	159	159
Modify Drawdown of Federal Funds by States		BA	30	1	1	1	1
		O	30	1	1	1	1

TABLE 1C. Continued

		1983	1984	1985	1986	1987
		(by fiscal year, in millions of dollars)				
Exclude Certain State Payments from Income	BA	0	0	0	0	0
	O	0	0	0	0	0
Total - AFDC	BA	133	134	159	160	160
	O	133	134	159	160	160
Supplemental Security Income (Function 600)						
Burial Plots	BA	5	5	5	5	5
	O	5	5	5	5	5
Unemployment Compensation Function (600)						
Allow states to reduce interest payments on loans	BA	95	151	162	-145	-96
	O	95	151	162	-145	-96
Federal supplemental unemployment compensation	BA	627				
	O	627				
Budget Authority impact of FUTA tax increase	BA	1,264	2,118	2,571	2,535	2,299
Medicaid (Function 550)						
Impacts of AFDC, SSI	BA	11	33	46	49	53
	O	11	33	46	49	53
TOTAL DIRECT SPENDING INCREASES	BA	3,462	4,591	5,744	6,231	6,900
	O	875	329	365	44	143

*Less than $1 million.

d/ Provision cannot be implemented until Secretary of HHS determines that implementation will not increase program costs. Because the provision would increase program costs unless modified, when implementation would occur is uncertain.

TABLE 1D. DETAILS OF AUTHORIZATION REDUCTIONS

	1983	1984	1985	1986	1987
	(By fiscal year, in millions of dollars)				
Food Stamps (Function 600)					
Impact of AFDC, SSI and Unemployment Compensation Provisions					
Estimated Authorization Change	-91	-53	-61	-62	-62
Outlays	-91	-53	-61	-62	-62
TOTAL AUTHORIZATION DECREASES					
Authorizations	-91	-53	-61	-62	-62
Outlays	-91	-53	-61	-62	-62

TABLE 1E. DETAILS OF AUTHORIZATION INCREASES

	1983	1984	1985	1986	1987
	(By fiscal year, in millions of dollars)				
Funding for employers share of federal employees medicare tax (Various Functions)					
Estimated Authorization	469	639	709	814	888
Outlays	494	673	746	857	935
Federal Supplemental Unemployment Compensation Administrative Costs (Function 600)					
Authorization	8	—	—	—	—
Outlays	8	—	—	—	—
Work Sharing (Function 600)					
Estimated Authorization Level	1	1	—	—	—
Outlays	1	1	—	—	—
TOTAL AUTHORIZATION INCREASES					
Authorizations	478	640	709	814	888
Outlays	503	674	746	857	935

6. BASIS OF ESTIMATE:

The budget authority and outlay estimates have been determined by CBO staff and are based on data from the Administration and other sources.

The spending estimates of the provision that extends Medicare taxes to federal employees include the effects of both employer and employee contributions to the Hospital Insurance (HI) trust fund. Contributions from both on- and off-budget employers are shown as increases to HI budget authority. The estimated authorization increases shown in Table 1E represent the amounts needed to fund projected contributions from on-budget federal employers to the trust fund. Because these amounts are offset by receipts shown in function 950, the contributions from on-budget employers do not have any net effect on budget outlays or the federal deficit.

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE: None.

9. ESTIMATE PREPARED BY:

Spending Provisions
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Lisa Potetz (226-2663)
Charles Seagrave (226-2820)

Revenues and Tax Expenditures
Jim Verdier (226-2687)

10. ESTIMATE APPROVED BY:

Charles Seagrave
for James L. Blum
Assistant Director
for Budget Analysis

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